Taking the Pulse of Primary Health Care Reform

Rethinking the way we do business: Template for the future

Focus on Payment Reform and Teams
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Faculty/Presenter Disclosure

Faculty: Rick Glazier

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- Consulting Fees: none
- Other: none
How We Pay for Health Care

- **hospitals**: global budget
- **long-term care**: number of beds
- **doctors**: FFS

→ few connections, perilous transitions
→ little support for care coordination

Paid from separate budgets

**Primary care physicians**
- few accountabilities
- weak measurement
- few networks
- little governance
- not many teams
- mostly FFS
- groups and solo
Primary Care Payment

• Physician payment negotiated
  • provincial Ministry and medical association
  • needs physician ratification
  • few agree to decreased fees, change in relativity
  • few changes can be made
  • large changes must be bought

• Payment reform commonly used as a tool to invest in primary care
Why Change is Needed

“Burning Platform is a business lexicon that emphasizes immediate and radical change due to dire circumstances.”

## EXHIBIT ES-1. OVERALL RANKING

<table>
<thead>
<tr>
<th>COUNTRY RANKINGS</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
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<th>US</th>
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<td>Top 2*</td>
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### OVERALL RANKING (2013)

<table>
<thead>
<tr>
<th>Category</th>
<th>AUS</th>
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<td><strong>Quality Care</strong></td>
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<tr>
<td><strong>Health Expenditures/Capita, 2011</strong></td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
<td>$4,495</td>
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<td>$5,643</td>
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Notes: * Includes ties. ** Expenditures shown in SUS PPP (purchasing power parity); Australian $ data are from 2010.

## Primary Care Transformation

### TABLE 1

<table>
<thead>
<tr>
<th>System-level Primary Health Care Initiatives</th>
<th>BC&lt;sup&gt;a&lt;/sup&gt;</th>
<th>AB&lt;sup&gt;b&lt;/sup&gt;</th>
<th>SK&lt;sup&gt;c&lt;/sup&gt;</th>
<th>MB&lt;sup&gt;d&lt;/sup&gt;</th>
<th>ON&lt;sup&gt;e&lt;/sup&gt;</th>
<th>QC&lt;sup&gt;f&lt;/sup&gt;</th>
<th>NB&lt;sup&gt;g&lt;/sup&gt;</th>
<th>PE&lt;sup&gt;h&lt;/sup&gt;</th>
<th>NS&lt;sup&gt;i&lt;/sup&gt;</th>
<th>NL&lt;sup&gt;j&lt;/sup&gt;</th>
<th>NT&lt;sup&gt;k&lt;/sup&gt;</th>
<th>YT&lt;sup&gt;l&lt;/sup&gt;</th>
<th>NU&lt;sup&gt;m&lt;/sup&gt;</th>
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<td>Group practices/networks</td>
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<td>Patient enrollment</td>
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<td>Payment/incentive schemes</td>
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</table>

Primary Care Transformation

Canadian Payment Reforms
FFS remains dominant

- B.C. chronic disease payments
- Alberta networks (PC, SCN), new staff, capitation pilots
- Ontario enrolment, capitation, teams, P4P
- Quebec groups with nurses, registration
- Others expanded roles, a few models, efforts to tweak FFS
# Ontario’s Large-Scale Experiment

## Exhibit 1

### Primary Care Organizational and Funding Models in Ontario

<table>
<thead>
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<tbody>
<tr>
<td>Physician reimbursement</td>
<td>Salary</td>
<td>Blended capitation</td>
<td>Blended fee-for-service</td>
<td>Blended fee-for-service</td>
<td>Blended fee-for-service</td>
<td>Blended capitation or blended salary</td>
<td>Blended capitation</td>
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<tr>
<td>Targeted financial incentives</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Formal patient enrollment</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Minimum group size (physicians)</td>
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<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Governance</td>
<td>Community board</td>
<td>Physician-led</td>
<td>Physician-led</td>
<td>Physician-led</td>
<td>Physician-led</td>
<td>Physician-led, community board, or mixed</td>
<td>Physician-led</td>
</tr>
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<td>Interprofessional team members</td>
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<td>Limited</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Limited</td>
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<tr>
<td>After-hours care requirements</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Optional</td>
<td>Yes</td>
<td>Yes</td>
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</tbody>
</table>

Hutchison B, Glazier RH. Health Affairs 2013:32:695-703
Transformation in Physician Payment

**EXHIBIT 2**

**Distribution Of Ontario Family Physicians, By Payment Model, 2002 And 2012**

- **2002**
  - Traditional FFS: 94%
  - Salary: 1%
  - Capitation: 2%
  - Salary-based blended payment: 2%
  - Capitation-based blended payment: 1%

- **2012**
  - Traditional FFS—Comprehensive Care: 12%
  - Traditional FFS—Focused Practice: 12%
  - Salary-based blended payment: 39%
  - Salary: 4%
  - Other: 2%

**Sources**

Ontario Ministry of Health and Long-Term Care and Institute for Clinical Evaluative Sciences. Note FFS is fee-for-service.

Hutchison B, Glazier R. Health Affairs 2013;32:1-9
Payments

EXHIBIT 4.3 Total payments to GP/FPs by payment source, in Ontario, 1992/93 to 2009/10

TOTAL PAYMENTS (THOUSANDS OF DOLLARS)
Successes

- Higher payment
  - FPs did not fall farther behind specialists
- Medical student choice of primary care
  - Canada-wide improvement
- More diverse and expanded roles
- High attachment
- Excellent patient experience
Most Canadians have a regular doctor or place where they receive care

Is there one doctor you usually go to for your medical care?

85% of Canadians have a usual doctor

93% of Canadians have a usual doctor or place they go to for medical care

How does Canada compare (2016)?

- France: 99%
- Netherlands: 99%
- Germany: 98%
- Norway: 95%
- New Zealand: 89%
- Australia: 86%
- CMWF average: 85%
- Switzerland: 85%
- Canada: 85%
- United Kingdom: 81%
- United States: 77%
- Sweden: 42%

Above average  |  Same as average  |  Below average

2016 Commonwealth Fund Survey
Provinces vary when it comes to perceptions of the health care system

|---------------------|------|--------|------|------|------|------|------|-------|-------|------|      |           |
| Is there one doctor | 85%  | 92%    | 85%  | 88%  | 75%  | 92%  | 83%  | 79%   | 84%   | 83%  | 85%  | 85%       |
| you usually go to  |      |        |      |      |      |      |      |       |       |      |      |           |
| for your medical   |      |        |      |      |      |      |      |       |       |      |      |           |
| care?              |      |        |      |      |      |      |      |       |       |      |      |           |
| Overall, how do     | 76%  | 77%    | 78%  | 76%  | 66%  | 76%  | 75%  | 75%   | 78%   | 77%  | 74%  | 65%       |
| you rate the       |      |        |      |      |      |      |      |       |       |      |      |           |
| medical care that   |      |        |      |      |      |      |      |       |       |      |      |           |
| you have received  |      |        |      |      |      |      |      |       |       |      |      |           |
| in the past 12      |      |        |      |      |      |      |      |       |       |      |      |           |
| months from your    |      |        |      |      |      |      |      |       |       |      |      |           |
| regular doctor’s    |      |        |      |      |      |      |      |       |       |      |      |           |
| practice or clinic? |      |        |      |      |      |      |      |       |       |      |      |           |
| (Excellent/very good)|      |        |      |      |      |      |      |       |       |      |      |           |

Above average  
Same as average  
Below average

2016 Commonwealth Fund Survey
Successes of the Ontario Transformation

Diabetes processes of care screening

Colorectal cancer

Kiran T et al CMAJ 2015
Successes of the Transformation (Canada)

Medical student choice for family medicine

Canadian Resident Matching Service
Ontario Payment Reform Challenges
Devil in the Details

- Increased costs
  - self-selection based on increased income
  - cancer screening, diabetes care incentives
- Selection of healthier practices
  - payment the same for healthy and sick patients
- Misalignment with system needs
  - 20% bonus if patients go to ED and not to walk-in clinics
- Timely access to care did not improve
- Improved processes of care, no cost savings yet
- No models changed in past decade: “paradigm freeze”
Access – Time Trends

Capitation Payments

Transition to Capitation: Selection

- Lower cost patients*
- More rural, more advantaged, average comorbidity**


** Glazier R et al. http://www.ices.on.ca/Publications/Atlases-and-Reports/2012/Comparison-of-Primary-Care-Models
Those Left Behind


Figure 1A-B. Percentage of patients receiving chronic disease management and prevention between 2001 and 2011 stratified by whether patient is attached to a medical home or a fee-for-service physician in 2011.

A. Recommended testing for diabetes

Figure 1C-D. Percentage of patients receiving chronic disease management and prevention between 2001 and 2011 stratified by whether patient is attached to a medical home or a fee-for-service physician in 2011.

C. Breast cancer screening
Payment and Team Reforms Across Canada
mostly add-ons to fee-for-service

• BC’s Complex Care Initiative
  • $315 annual payment, in addition to regular visit fees (FFS)
  • responsibility for longitudinal, coordinated care of the patient
  • impact mixed but access, continuity, utilization not impacted

• Alberta’s PCNs
  • “… funding methodology does not align with their need for consistent, sustainable funding, nor does it address the complexity of patient health care needs”

• Quebec’s FMGs
  • slight improvements in accessibility of care and responsiveness
  • “does not seem to have had an impact on continuity, comprehensiveness, perceived care outcomes, use of services, and unmet needs.”

http://www.health.alberta.ca/initiatives/PCN-review.html
Pineault, R. International Journal of Family Medicine Volume 2016, Article ID 8938420
Payment Reform

- Fee-for-service
  - rewards volume – pros and cons
  - hard to support team work, QI activities, care coordination, accountability
  - so far add-on fees have had mixed results

- Capitation
  - aligns with system goals of cost savings, shifting risk
  - highly rated by providers (who choose it)
  - details are key: risk adjustment, negation, avoid perverse incentives

- Payment
  - is only one building block, won’t work by itself
  - must support accountability, measurement, teams
  - align with system needs for integration, coordination
Parting Words

“Primary Care In Canada: So Much Innovation, So Little Change”
Brian Hutchison, Julia Abelson, and John Lavis
Health Affairs 2001

“More than anything else though, what Canada needs to fix its systemic health-care woes is to create a semblance of a system.”
André Picard, Globe and Mail 2017