Blueprint for Comprehensive Primary Health Care Reform in Ontario*

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EXECUTIVE SUMMARY

The purpose of this brief is to outline a series of financing, delivery and organizational mechanisms that both extend the spirit of the *Canada Health Act* to in-home continuing care and advance the integration of such care with proposals to reform primary care. To achieve this goal, three principles are invoked: first, reforms should be introduced with incentives that further health service integration; second, the comprehensiveness principle captured in the *Canada Health Act* should be broadened to include necessary health care wherever that care is sought, delivered and received; and finally, mechanisms that constrain government liabilities should be included in any reform package.

Following an introduction, Section 2.0 outlines health care in Canada and Ontario, with an emphasis on expenditure and financing trends, and the associated policy context. Section 3.0 provides an overview of home care with discussion of two distinct groups of clients and their associated service profiles. Here, in-home continuing care is framed as a service that should be integrated with primary care, while in-home care following hospitalization should be integrated with hospital services. Accordingly, in Section 4.0, mechanisms for the financing, delivery and organization of primary care that incorporates in-home continuing care are described. Estimates of the cost of primary health care organized through use of Primary Care Groups (PCGs) are offered in Section 5.0. A short conclusion with recommendations for primary health care reform is offered in Section 6.0.

Comprehensive (not piecemeal) primary health care reform is recommended in this brief. We propose mechanisms to advance the establishment of Primary Care Groups (PCG) as a model for primary health care reform. We recommend that such PCGs be publicly financed through risk-adjusted capitation fees in return for the provision of a comprehensive range of primary care services offered by an integrated team of health care professionals. This team would include physicians, nurses, specialized therapists, community pharmacists, and personal support workers. In order to enhance service integration at the level of primary care, we also recommend that the services offered by each PCG include in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services. To further accessibility, we suggest that an integrated team of health professionals, with a minimum of 3-5 physicians, should provide a comprehensive range of primary care services to roster patients-clients, 24 hours a day, seven days a week. We further recommend that each PCG be owned and operated by regulated health care professionals, so as to ensure shared goals for service delivery, resource utilization and clinical outcomes.

The proposed model for comprehensive primary health care reform allows for patient choice in the selection of their preferred Primary Care Group (PCG); it provides physicians with the autonomy to practice in a PCG or to remain under current fee-for-service arrangements; it advances health services integration across a range of

complementary services; and it has the potential to improve the efficient, effective and equitable allocation of primary care services to the residents of Ontario without compromising the fiscal integrity of the provincial government.

The recommendations advanced in the body of the report are consistent with the three principles described at the outset, namely, to enhance primary care service integration; to ensure Canadians have access to necessary primary care services irrespective of where such care is sought, delivered or received; and to limit government liabilities.

Recommendation 1: We recommend limiting government liability by implementing a fixed funding envelope for Primary Care Groups (PCGs). This envelope should provide funding for a comprehensive range of primary care services offered by each PCG including in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

Recommendation 2: Reimbursement for PCGs should be structured according to a risk-adjusted capitation method of payment.

Recommendation 3: Obstacles to the in-house provision of allied health services by PCGs should be removed.

Recommendation 4: Mechanisms should be designed to facilitate the development of contractual arrangements between PCGs and specialty care providers, including in-home continuing care providers, community pharmacists and diagnostic service providers.

Recommendation 5: Contractual agreements concerning price and outcome expectations negotiated between PCGs and speciality care providers, including in-home continuing care providers, community pharmacists and diagnostic service providers, should be subject to public scrutiny.

Recommendation 6: PCGs, managed by a member (or members) of a regulated health profession (i.e. physicians, nurses, pharmacists, etc.), would consist of a minimum of 3-5 primary care physicians along with an integrated team of health professionals. This would allow for the provision of comprehensive and accessible care; 24 hours a day, seven days a week.

Recommendation 7: Financing for post-acute home care (PAHC) should be directed to hospitals, and funding for in-home continuing care should be directed to PCGs. However, the home care envelope should be monitored on a regular basis to ensure the appropriate provision of such care.

Recommendation 8: We recommend that patients-clients be granted the opportunity to roster with a single PCG of their choosing.

Recommendation 9: We recommend that patients have the option to terminate their agreement with a PCG and roster with a different PCG of their choice.

Recommendation 10: We recommend that funding for a comprehensive range of primary health care services provided by a single organizational entity be 25% larger than the current level of funding to ensure rapid transition towards the formation of PCGs.

Recommendation 11: We recommend that PCGs receive an annual fee of $566 per roster patient (in fiscal year 2003 dollars) in return for the provision of a comprehensive and accessible range of primary health care services, including in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

1.0 Introduction

Health care in the 21st century consists of more than institutional settings and stethoscopes; it involves more than one privileged place (hospitals) and one privileged provider (physicians). Today, health care is sought, delivered and received in a wide variety of settings, is often provided by an increasing complex array of health professionals, and is frequently mediated by user friendly and miniaturized technologies (Coyte & McKeever 2001a, 2001b; McKeever & Coyte, 2002). Indeed, the sampling of technologically sophisticated health care provided by an array of health care providers in many different settings is the dominant characteristic of the new health care order.

In the light of these developments in the organization and delivery of health care, the *Canada Health Act* has become increasingly irrelevant as the majority of care is beyond the scope of this legislation. Canadians expect the federal government will take steps to ensure that publicly funded health care conforms to the five principles of universality, accessibility, comprehensiveness, portability, and public administration embedded in the *Canada Health Act*. However, an exclusive focus on medically necessary *hospital* and *physician* care restricts both the federal and provincial government's opportunity to ensure that Canadians have access to *necessary* health care *wherever* that care is delivered. As such, the principle of comprehensiveness needs to be expanded, such that the setting for necessary care does not affect its funding.

A series of financing, delivery and organizational mechanisms designed to extend the spirit of the *Canada Health Act* to health care services and technologies previously provided within a hospital setting, but are now available to Canadians where they reside, were recommended by the Senate (2002) and Mr. Romanov (2002). However, these recommendations focused on post-acute home care services, i.e. in-home services following discharge from hospital care. While post-acute home care has become increasingly important, the largest proportion of in-home service expenditures address the continuing care needs of Canadians. Moreover, there is significant scope for a closer alignment of in-home continuing care services and those offered by primary care providers and community pharmacists.

The purpose of this brief is to outline a series of financing, delivery and organizational mechanisms that both extend the spirit of the *Canada Health Act* to in-home continuing care and advance the integration of such care with proposals to reform primary care. To achieve this goal, three principles are invoked: first, reforms should be introduced with incentives that further health service integration; second, the comprehensiveness principle captured in the *Canada Health Act* should be broadened to include necessary health care wherever that care is sought, delivered and received; and finally, mechanisms that constrain government liabilities should be included in any reform package.

The comprehensive primary health care reform model, which incorporates the integration and delivery of in-home continuing care, outlined in this report represents a natural extension of efforts to transform primary care in Ontario. This vision for reform is consistent with current government policy as it advances the provision of comprehensive, cost-effective, and appropriate health care services responsive to patient/client choice. The proposed model provides for patient

choice in the selection of their preferred Primary Care Group (PCG); it offers physicians the autonomy to choose to practice in a PCG or to remain under current fee-for-service arrangements; it advances health services integration across a range of complementary services; and without compromising the fiscal integrity of the provincial government, our model has the potential to improve the efficient, effective and equitable allocation of primary care services to the residents of Ontario. In short, a "macro" plan for comprehensive primary health care reform is outlined.

The model for primary health care reform recommended is compatible with the reform options advanced elsewhere and builds on the definition of primary care used by Lamarche *et al* (2003), namely, the "set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive, and palliative services".

This report begins with an outline of health care in Canada and Ontario, in Section 2.0, with an emphasis on expenditure and financing trends, and the associated policy context. Section 3.0 provides an overview of home care with discussion of two distinct groups of clients and their associated service profiles. Here, in-home continuing care is framed as a service that should be integrated with primary care, while in-home care following hospitalization should be integrated with hospital services. Accordingly, in Section 4.0, mechanisms for the financing, delivery and organization of primary health care that incorporates in-home continuing care are described. Estimates of the cost of primary health care organized through the use of Primary Care Groups (PCGs) are offered in Section 5.0. A short conclusion with recommendations for comprehensive primary care reform is offered in Section 6.0.

2.0 General Trends in Health Care

Canadian health expenditures have increased dramatically in the last forty years, and moreover, have increased more rapidly than any other component of government spending. Given the magnitude of the increase in health expenditures, which account for 30-40% of all provincial spending, this sector cannot be immune from significant restructuring. In this Section, we review health expenditure trends in Canada and Ontario in order to provide insight into the fiscal context of primary health care reform.

2.1.0 Health Care Trends in Canada

In Canada, just as in other Western countries, health expenditures have increased dramatically in the last forty years and are still increasing.[a] In 1960, health expenditures represented 5.5% of Canada's Gross Domestic Product (GDP), Figure 1. Today, $121,430.8 million (10.0% of GDP or

[a] Concern over increased health-spending stems from the realization that it has a negative impact on disposable income, it potentially retards global competitiveness, and it significantly reduces the fiscal flexibility of governments.

$3,839.14 per capita) is spent on health (Health Canada, 1997, and CIHI, 2003). This surge in the proportion of society's resources devoted to health is equivalent to a 1.4% average annual compounded rate of increase in health spending over and above both inflation and the real growth in the economy.

The various components of health expenditures and their share of all health spending are reported in Table 1. Over the last thirty years there has been a notable shift away from hospital care (44.7% to 30.0%) towards other treatments and settings, particularly pharmaceuticals (8.8% to 16.2%) and home and community care, which is included in the other expenditures category (8.8% to 14.9%). Slightly less emphasis is now placed on physicians (15.1% to 12.9%), and more reliance is placed on other health professionals (9.0% to 11.9%).

While there are several explanations for the increase in the share of society's resources devoted to health, four dominant factors account for this period of expenditure growth: growth in the number of health professionals; increased health care utilization; the diffusion and uptake of increasingly sophisticated and user friendly health service technologies; and the aging of the population.

One of the major concerns facing the health sector in Canada is the magnitude of the impact of the aging of the population on health expenditures. Between 1960 and 2003 real per capita health expenditures in Canada grew at an average annual rate of 3.7%, Table 2. Over this period, the percentage of the population over sixty five increased from 7.6% to 12.8% (Statistics Canada, 2001 and 2003). This increase in the proportion of elderly Canadians accounted for 8.4% of the annual percentage increase in real per capita health expenditures, or approximately 0.3 percentage points of the annual increase of 3.7%.[b]

Population projections by Statistics Canada (2000 and 2003a) suggest that the number of Canadians over sixty five will almost double between 2003 and 2026, at which time they will represent 21.5% of all Canadians, Table 3. Since the elderly utilize health care resources more intensively than the young, indeed by a factor of 4.5 (Boulet an Grenier, 1978) to 4.7 (Health Canada, 1997), it is anticipated that the aging of the population will continue to exert an independent effect on health expenditure inflation. Calculations of this impact, for the next quarter century, suggest that the aging of the population will raise real per capita health expenditures by 0.8 percentage points, annually. This increase is more than double the inflationary impact recorded between 1960 and 2003, and is therefore a cause for concern for those charged with health cost containment policies.

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[b] This figure was obtained by first calculating per capita health expenditures for Canadians over 65 and for those under 65 (Health Canada, 1997). By applying the percentage of the population at two points in time to such relative expenditures, average per capita health expenditures may be calculated that depends solely on the age distribution of the population.

2.1.1 Health Care in Ontario

Health care trends in Ontario, Canada's most populous province, with 12.2 million people and 39% of Canada's population provide a useful provincial perspective to the federal trends (Statistics Canada, 2003a and 2003b). Here health expenditure trends in Ontario are described for three discrete periods. The decade of expenditure growth: 1980 to 1991; the period of restraint: 1991 to 1997; and the period of expenditure resurgence: 1997 to date.

Just as federal health expenditures have grown so have expenditures in Ontario. Indeed, the average annual rate of growth of total health expenditures in Ontario was 12.0% between 1980 and 1991 (CIHI, 2003). This increase was greater than that recorded in any other province, and more than 20% greater than the annual growth rate in the rest of Canada, 12.0% vs. 9.3%. (CIHI, 2003).

Ontario government health expenditure growth between 1980 and 1991 was significant, Figures 2 and 3. Indeed, the average annual growth rate of inflation-adjusted health expenditures and inflation-adjusted per capita health expenditures were 5.6% and 3.9%, respectively. This surge in provincial health spending accounts for: the declining share of federal contributions for health, the increasing share of provincial expenditures, and the growth in the proportion of GDP devoted to health.

One of the most dramatic increases in health expenditures was in the area of physician services. Indeed, these expenditures grew at an average annual rate of 13.2% and their share in total health expenditures went from 16.0% in 1980 to 18.4% in 1991 (CIHI, 1998a). While a portion of the increase in physician expenditures was due to population growth, averaging 1.6% per annum (CIHI, 1998b), and a higher schedule of benefits for physician services, averaging 5.8% per annum (Health Canada, 1994), much of the increase was due to increased utilization, averaging 5.8% per annum, Health Canada (1997) and Barer *et al* (1988).

After several years of uninterrupted growth, the Ontario economy moved into recession between 1989 and 1990. The prospect of declining revenues from provincial sources, diminished federal transfers and a recession-induced increase in the use of publicly provided services, presented the provincial government with a major policy dilemma. Notwithstanding the increased need for publicly provided services, even the maintenance of existing service levels would have both significantly increased the provincial deficit and restricted future fiscal flexibility.

In the light of these financial circumstances, it was not surprising to find that pressure to contain costs were imposed on many areas of government activity, but particularly in the health field beginning in 1992, Figures 2 and 3. Health expenditures were singled out for specific attention as they represented the single largest component of provincial government spending and they had increased more rapidly than other government expenditures.

Between 1992 and 1997 health spending increased by 1.4% in total (CIHI, 2003), while inflation over this period was 7.9%. As a result, inflation-adjusted health expenditures fell by 6.1% between 1992 and 1997, Figure 2. After adjusting for the growth in the population, inflation-adjusted per

capita health expenditures in Ontario fell by 11.6% between 1992 and 1997, Figure 3. Although the downturn in inflation-adjusted per capita health expenditures was large, such expenditures in 1997 were still 11.4% higher than equivalent expenditures in 1985 and 37.5% higher than such expenditures in 1980, Figure 3.

While the inflation-adjusted per capita GDP in Ontario began to increase in 1993, the provincial deficit was not removed until 1999. The prospect of this improvement in economic fortune presented the Ontario government with the fiscal flexibility to increase health expenditures. Between 1997 and 2003, annual health expenditures in Ontario increased by more than ten billion dollars or 52.9%. This increase was approximately four times the inflation rate (14.3%) and about six times the growth in the population (9.0%). In 2003, about 40% of all provincial government spending was devoted to health, exceeding the 34% recorded in 1991. After adjusting for both population growth and inflation, health spending in Ontario in 2003 was 22.7% greater than it was in 1997, 11.1% larger than in 1991, and finally, 68.8% larger than in fiscal year 1980, Figure 3.

The 1990s began as an era of significant fiscal restraint and ended in a stampede of political parties, during the course of the June 1999 Ontario election, and to a lesser extent during the 2003 campaign, to out-commit to spend on health care services. At the same time, the intersection of fiscal pressures, medical and technological advances, the changing age structure of the population, and the recent Health Accord between the federal and provincial governments (First Ministers of Canada, 2003), offers a very timely catalyst to significantly restructure health care in Ontario for the 21st century.

The new health care order has resulted in the transfer of a broad spectrum of care to an array of health care settings with particular reliance on the family home. This shift in the setting for care is one of the most significant social changes in the last two decades that will have repercussions throughout the new millennium. Indeed, this change has opened the door for a major reallocation of health costs from the public to the private realm, thereby eroding what has become recognized as one of the hallmarks of Canadian identity. Today, health care is sought, delivered and received in a wide variety of settings, is often provided by an increasing complex array of health professionals, and is frequently mediated by sophisticated technologies (Coyte & McKeever 2001a, 2001b; McKeever & Coyte, 2002). While the health sector is in an ongoing state of renewal, the institutions designed to regulate publicly funded health care, such as the Canada Health Act, are increasingly viewed as irrelevant structures as most services lie outside their ambit.

Given both the level of political support for publicly financed health care in Ontario and the windfall of federal funds derived from the Health Accord (First Ministers of Canada, 2003), the time is ripe for health service renewal, particularly in the areas of primary and in-home care. Although many services associated with in-home care are integral to primary care, there is a major disconnect between these sectors. Consequently, the series of recommendations advanced in this report are designed to extend the spirit of the *Canada Health Act* to in-home continuing care and to advance the integration of such care within primary care.

3.0 Overview of Home Care in Ontario

One setting that has become an important feature of the new landscape for health care has been the home. Within that setting, a complex array of services, products and technologies are combined with unpaid care provided by family members, friends and volunteers to advance the health and well being of Canadians. Under the home care designation, many agencies and providers participate in the provision of health and lifestyle enhancement services. The range of services is large, including nursing, social work, physiotherapy, occupational therapy, meals on wheels, and personal support. In this Section, we provide an overview of home care trends and we highlight two distinct groups of clients served and their associated service profiles

Home Care Expenditure Growth Greater in the Private Sector:
In the last twenty years, while there has been dramatic growth in home care expenditures that may be attributed to improvements in beneficiary eligibility, accessibility, demographic change, technological change and health service restructuring, there have been both temporal and sectoral differences in rates of growth. Figure 4 portrays the growth of public home care expenditures since 1980. Despite rapid annual growth of 17.2% during in the 1980s, the annual rate of growth of public home care expenditures fell to 10.4% during the 1990s, and declined further to 8.9% for the period following 1995. In contrast, the rate of growth of private home care expenditures has accelerated over the last two decades as shown in Figure 5. The annual growth rate of private expenditures, which was 9.4% during the 1980s, increased to 13.0% during the 1990s, and increased further to an annual rate of 15.6% for the period since 1995. Consequently, despite the public rhetoric about the importance of home care, the public sector's share of total home care expenditures has fallen in the last decade, and represents less than 80% of this industry which in 2001 was $3.5 billion (Health Canada, 2001) and today is approximately $4 billion.

Current Delivery of Home Care:
In recent decades, the delivery of publicly funded in-home care has undergone considerable restructuring and change in Ontario. In 1996, the province modified the methods of in-home health service organization, finance and delivery through the establishment of 43 regionally distinct Community Care Access Centres (CCACs) (Williams, 1996). Previously, provincial Home Care Programs serviced home care clients directly. Currently, CCACs receive a prospective global budget from the Ministry of Health and Long-Term Care, and purchase services from "external" service providers on a contractual basis. In addition to contract management and adjudication, the CCACs employ case managers who assess client needs, develop service plans, perform long-term care placement and coordination services, and are engaged in the provision of information and referral services. For fiscal year 2003, the budget for in-home services administered through CCACs was $1.160 billion or just over 4% of budgeted health expenditures in Ontario.

Distinctive Home Care Recipients:
While many individuals receive home care services to prevent or retard the deterioration of health and to assist them to maintain independence in the community, others receive such services for a short period of rehabilitation following hospitalization. The former are recipients of in-home continuing care, while the latter are post-acute home care recipients. Recent hospital

transformations through closures, mergers, dramatic reductions in lengths of stay, and radical changes to the size and function of hospitals have altered the home care caseload, with a heavier emphasis on post-acute home care recipients often to the exclusion of continuing care clients who have long standing needs.

Distinctive Service Profiles:
Home care is no longer the preserve of the elderly. Forty five percent of home care recipients in Ontario are under 65 years of age and fifteen percent are children (Laporte *et al.*, 2001). Moreover, the service profiles are distinct for the two main groups of home care clients. One group receives care for a short period of generally less than 90 days; and the other group receives care on an on-going or continuing basis. For short-term recipients, nursing services makes up the lion's share (63.0%) of in-home services received, with the remaining services divided between personal support (20.6%) and various other therapies (16.4%). In contrast, among in-home continuing care recipients, personal support is the most prevalent service received (59.2%), followed by nursing (35.5%), while therapy services are rarely received (Laporte *et al.*, 2001).

Health Policy Assumptions Driving Change:
Health care practices have radically changed in the last two decades and broad spectrum of formerly publicly funded services is now delivered in the home, and more frequently, is financed through the private sector. This shift towards greater reliance on in-home care has been based on three commonly held assumptions.

First, it is believed that Canadians want to assume substantially greater responsibility for health care delivery at home; that they want to be discharged from acute care early; and that they want to remain in the community rather than be residents of long-term care facilities. However, evidence for this contention is rarely presented.

Second, it is further assumed that Canadian housing and employment circumstances permit the shift of safe and effective care to the home. However, even the finest modern home was not designed to facilitate the long-term provision of care, and moreover, changes to patterns of labour force participation and other competing demands on the time of unpaid caregivers raise questions about whether such caregivers will be available in the future (Keating *et al.*, 1999).

Finally, it is commonly assumed that equal or better care at a lower cost will result by shifting care from institutions to the home (Jackson, 1994; Hollander, 1994; Jacobs *et al.*, 1995). Two Canadian studies have reported that home care may lower public sector costs without adversely affecting the health of Canadians (SHSURC, 1998; Hollander, 1999). However, a broader review of the literature suggests first, that there is very little compelling evidence that home care is cost-effective (Parr, 1996; Price Waterhouse, 1989; FPT Work Group, 1990; Weissert *et al.*, 1980; Weissert, 1985; Weissert, 1991; PriceWaterhouseCoopers, 1999), and second, that any cost-savings achieved through home care tend to privilege the public sector, resulting in cost shifting to care recipients and their family.

4.0 Comprehensive Primary Health Care Reform

In the light of an array of reform principles, the 2003 Health Accord (First Ministers of Canada, 2003), and the current fiscal circumstances facing the Ontario provincial government, this Section explores pragmatic options for comprehensive primary health care reform. The reform model integrates the organization, finance and delivery of in-home continuing care with primary care, and thereby, represents a natural extension of efforts to transform primary care. The vision for reform articulated in this report is consistent with current government policy as it advances the provision of comprehensive, cost-effective, and appropriate health care services responsive to patient/client choice.

Unlike previous reform proposals, which focused exclusively on either issues of physician reimbursement (ACHHRS, 1995) or organizational change (Leatt *et al.*, 1996), here we offer a more comprehensive model for reform. While a wide ranging set of pluralistic options for primary care reform were recommended by Lamarche *et al* (2003), we are more prescriptive on those options. Recent national reports (Kirby, 2002; Romanow, 2002) support the emergence of Primary Care Groups (PCGs), they emphasize the importance of health service integration, and highlight the need to broaden the comprehensiveness principle captured under the *Canada Health Act*. Consequently, our model uses the structural foundation of PCGs as a vehicle to reform, in a coordinated manner, both primary care and in-home continuing care.

While it is impossible to exhaustively review and evaluate all current and potential patterns of medical practice, we have decided to adopt a more selective approach. In this report, we outline options for reform that address five main components of the reform process, namely: limiting government liability exposure; reimbursement alternatives for health professionals; organizational change; service integration; and patient-client choice.

4.1 Limits to Government: Envelope of Primary Health Care Services

There is a common Canadian misconception that the current funding and delivering mechanisms for health care services are somehow unique to Canada. Indeed, there is the common belief that such arrangements are akin to a "sacred trust" that sets Canada apart from other Nations. This perception contrasts with the current reality as public sector support for health care is present in all Western countries, and such support often yields a comprehensive basket of services that is generally universally available to all residents.

Moreover, the perception that Canadians *have* universal and comprehensive health insurance for *all* medically necessary health care services is factually incorrect (General Accounting Office, 1991). Rather, Canadians have limited (not comprehensive) coverage and unequal (not equal) access to publicly insured health care services. Health insurance coverage in Canada is limited as public sector expenditure restraint rations access to and limits the availability of health care services. Such health care rationing is not applied equally to all Canadians as factors such as socio-economic status influence access (Manga, 1978; McIsaac *et al.*, 1991; Alter *et al*., 1999; Dunlop *et al*., 2000; Wilson and Rosenberg, 2003). Canadian residents neither have equal access

to primary care services nor to specialty care. Thus, multi-tiered access to health care is a current Canadian reality.

Patients-clients require referral by primary care providers if they are to receive publicly financed diagnostic or specialty services. Without a primary care referral, patients-clients are unable to access these publicly financed services. They may, however, receive services that are not publicly financed without a primary care referral by financing the cost of these services privately, either through health insurance or direct payments.[c] As a result of these referral restrictions, primary care physicians have the potential to play an important and effective gate-keeping role in restraining the growth of health expenditures.

Under the delivery and organization of primary care groups, we adopt the definition of primary health care used by Lamarche *et al* (2003), namely the "set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive, and palliative services". While such services provided by physicians are currently insured by the provincial government and captured under primary care, we here recommend expanding the envelope of insured primary health care services to include in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

In our proposed model, Primary Care Groups (PCGs) would receive risk-adjusted capitation payments for a pre-defined comprehensive range of primary health care services. Risk-adjusted funding would be based on the population profile being served by the PCG, and would vary by region. The implementation of a fixed funding envelope for primary health care encourages providers to work and operate collectively within a budget. Additionally, capitation-based reimbursement would motivate the group to offer health maintenance services to its enrolled population (HSRC, 1999).

The Home as the Health Care Hub:

Current discussion of home care as a substitute for acute or institutional care is misplaced. That discussion forces a bifurcation between the entrenched interests of medicare, on the one hand, and home and community care, on the other. Health care is sought, delivered and received in an array of settings and is mediated by (paid and unpaid) providers of care and health technologies, including medical products. These configurations of people, places and technologies are as diverse as the underlying health needs of the population. Moreover, the episodic nature of health care (diagnosis, intervention/cure, recovery/rehabilitation, and health maintenance) along with medical specialization, ensure that investments in health occur sporadically and in a range of distinct settings.

From the perspective of care recipients who encounter the new health care order on a daily basis, such geographically distinct and organizationally separate settings for health care are antithetical to

[c] While not directly subsidized, these payments are potentially tax deductible.

their interests. Equipped with separate missions, visions, and organizational goals and confronted with distinct economic incentives, it is not surprising to find behavioural inconsistencies in the actions taken and the positions adopted by the various health care organizations and institutions. These inconsistencies frequently yield unintended adverse consequences, such as poor continuity of care, which results from the expectation that care recipients should "follow" providers, rather than for care providers to "follow" recipients.

By viewing the home and the health care services received therein as a complement to care sought, delivered and received in other settings, a more powerful method of visioning health care for the 21st century may be gleaned. Rather than developing yet another geographically separate and organizationally distinct "silo" funding program, a concerted effort is needed to provide incentives to the provinces, health service organizations and providers to integrate service provision across networks of care.

Conversely, we propose that irrespective of the setting in which care is sought, delivered or received, it is the care recipient and his/her necessary health care needs that should be funded. Elsewhere, Coyte (2002) has argued that the funding of post-acute home care be with the hospital-funding envelope. Here we propose that funding for in-home continuing care be integrated with funding for primary care groups (PCGs). Such funding and organizational change may offer opportunities to enhance service effectiveness and efficiency, and should be coupled with on going monitoring activities to ensure the advancement of various equity objectives.

Recommendation 1: We recommend limiting government liability by implementing a fixed funding envelope for Primary Care Groups (PCGs). This envelope should provide funding for a comprehensive range of primary care services offered by each PCG including in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

4.2.0 Methods of Physician / Health Service Organization Reimbursement

Primary care physicians are at the centre of health care reform proposals as they generally represent the first point of contact for patients-clients with the health sector. The overwhelming majority of these physicians work in solo practices and are reimbursed on a fee-for-service basis by provincial health plans for the provision of medically necessary services. They act as agents for an increasingly informed and assertive population of patients-clients. As a result, physicians have been forced to struggle with the conflicting demands of their patients (for increased health service intensity) and their assigned role as gatekeepers to the health sector.

The literature on physician / health service organization reimbursement mechanisms is vast (Hurst, 1991; Kristiansen *et al.*, 1993; Stoddart & Barer, 1991), ranging from issues that pertain to a single jurisdiction (Birch *et al.*, 1994) to others that are more generic (Gabel & Redisch, 1979; Woodward & Warren-Boulton, 1984). Indeed, a literature review conducted for the Ontario Medical Association's Subcommittee on Health-Care Financing (Coyte, 1995), concluded that there was no single reimbursement scheme yielding incentives for adequate physician compensation and efficient

clinical practice that was also compatible with the provision of comprehensive, cost-effective, and appropriate health care services for patients (and taxpayers). While some aspects of each payment scheme yielded benefits to society, none were without defects.

In Section 4.2.1 to 4.2.3 we briefly discuss three common methods of reimbursing physicians/health service organizations (fee-for-service, capitation, and salary), we evaluate each of the payment schemes. Section 4.2.4 highlights our preferred method of reimbursement in our proposed primary health care reform model.

4.2.1 Fee-For-Service Reimbursement

Most physicians are reimbursed on a fee-for-service basis, but the overwhelming consensus within health policy, academic, and government circles is that the fee-for-service method of reimbursement provides incentives for service generation in order to enhance earnings, particularly when patients are less informed about the attributes of the services provided than physicians (Coyte, 1995; Gabel, 1979; Evans, 1974; Pauly & Satterthwaite, 1981). From the perspective of provincial governments, fee-for-service reimbursement represents a significant financial liability. Moreover, even if global payments were capped (Barer *et al.*, 1988; Ade & Henke, 1991; Kirkman-Liff, 1990), this payment scheme may result in inter-specialty concerns regarding income and service intensity inequality, particularly between procedure-intensive specialties and other groups.

4.2.2 Capitation Reimbursement

There are a wide variety of capitation-based reimbursement schemes. One particular example is where health service organizations (HSOs) are reimbursed on the basis of prospectively determined capitation payments. Such capitation payments reward the HSO for the provision of health care services to roster patients, but may be associated with the under- or over-utilization of diagnostic services and specialty care if the capitation payment includes or excludes the anticipated cost of those services, respectively (Gabel & Redisch, 1979; Rodwin, 1989). Capitation schemes provide HSOs with the incentive to attract healthy patients and to discourage those with high service demands. While competition for patients may result in the provision of health promotion services, may enhance task delegation, and may raise patient satisfaction, it is also possible that the reverse may arise relative to the current fee-for-service reimbursement scheme if mechanisms that monitor service provision are absent.

4.2.3 Salary Reimbursement

Since there is no direct relationship between service provision and the payment of salaried health care providers, salary reimbursement does not provide members of the health care team with incentives to attract roster patients, provide services, or offer patients quality care. Such providers neither face incentives to practice efficiently nor to restrain their propensity to refer patients for diagnostic services or specialty care. Salaried providers do, however, have incentives to engage in non-patient care activities, such as teaching and research without financial cost, and these advantages may account for their adoption in teaching health science centres (Haslam & Walker,

1993). Overall, relative to fee-for-service arrangements, there is the expectation that salaried providers would be less efficient (Gabel & Redisch, 1979), exhibit greater practice costs, see fewer patients with less intensive forms of care, and have a greater propensity to refer patients for diagnostic services and specialty care.

4.2.4 Evaluation of Reimbursement Schemes

While the salaried method of provider payment may advance the objectives of teaching health science centres, it has only a limited role in the provision of comprehensive, cost-effective, and appropriate primary health care services that would be responsive to patient-client choice. The other payment schemes contribute to these health sector objectives in one way or another, but no payment scheme has all the answers.

Under the model proposed in this report, groups of 3-5 primary care physicians should be affiliated with each primary care group (PCG). These physicians will share on-call shifts in order to provide rostered patients with comprehensive and accessible care; 24 hours a day, seven days a week. We support the gradual adoption of a capitation payment scheme for the reimbursement of PCGs, where such PCGs would provide a comprehensive range of primary health care services through use of an integrated team of health care professionals including physicians, nurses, specialized therapists, community pharmacists, and personal support workers. Under this system of reimbursement, PCGs would receive risk-adjusted capitation payments for the provision of services to a group of rostered patients. These risk-adjusted payments should be based upon the illness profile of both the community and individuals served. Such reimbursement arrangements address concerns raised about the financial risks faced by PCG when attracting roster patients, and thereby, minimize the incentives faced by PCGs to attract only healthy residents.

Recommendation 2: Reimbursement for PCGs should be structured according to a risk-adjusted capitation method of payment.

4.3 Health Care Financing and Delivery Model

Modifications to the method by which PCGs are reimbursed for the provision of health care services will significantly affect the manner by which health care is organized and delivered. Similarly, the manner in which funds are allocated and the mechanisms used to assign responsibility for the organization and delivery of such care is tremendously important in advancing various policy goals: limiting the liability exposure of various levels of government; supporting service integration; and enhancing the efficient, effective and equitable allocation and use of health care services. Indeed, the adoption of a capitation payment scheme of the type recommended encourages service integration for health service organizations so that the financial risks to PCGs from service provision are minimized. Since this form of organizational arrangement enhances opportunities to monitor the utilization of health care services, it will strengthen the continuity of care and service co-ordination. Such health sector restructuring may yield improvements in quality service provision, health care costs, and patient satisfaction. Moreover, the introduction of the capitation payment scheme is expected to result in the rapid growth of integrated primary care groups.

To the extent to which integrated PCGs are able to take advantage of economies of scale and scope in the provision of specialized services, such as in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services, then such organizations may provide these specialized services themselves. Such in-house service provision helps integrated health delivery organizations hire and monitor allied health professionals with complementary competencies, and it enhances team work and task delegation. It also affords the delivery of in-home continuing care within this integrated system. Such delivery options provide organizations with the opportunity to ensure that the most appropriate quality provider services patients-clients.

Recommendation 3: Obstacles to the in-house provision of allied health services by PCGs should be removed.

The capitation payment scheme accentuates the gatekeeper role for PCGs. This payment scheme provides such organizations with opportunities to pursue contractual arrangements with allied health professionals either through in-house service provision or through selective contracting. Mechanisms should be designed to facilitate the development of these contractual arrangements, as the public interest would be served through increased health service integration.

Recommendation 4: Mechanisms should be designed to facilitate the development of contractual arrangements between PCGs and specialty care providers, including in-home continuing care providers, community pharmacists and diagnostic service providers.

Recommendation 5: Contractual agreements concerning price and outcome expectations negotiated between PCGs and speciality care providers, including in-home continuing care providers, community pharmacists and diagnostic service providers, should be subject to public scrutiny.

We recommend that PCGs be managed by a member (or members) of a regulated health profession (i.e. a physician, nurse, pharmacist, etc.) as a single business unit. While we also recommend that risk-adjusted capitation payments be used to reimburse PCGs, each individual provider either employed by or under a contractual relationship with the PCG may be reimbursed under other mutually satisfactory arrangements. This management structure ensures shared goals and outcomes for service delivery, resource utilization and clinical outcomes (HSRC, 1999).

Additionally, the prescribed PCG model would allow patient-clients access to care 24 hours a day, seven days a week. The composition of PCGs consists of an integrated team of health professionals, where the primary health care team is formed by a minimum of 3-5 primary care physicians along with an integrated team of health professionals. These physicians would share on-call coverage during evenings, weekends and holidays. The prescribed ideal team size of around five primary care physicians will allow for effective group interactions and quality health care delivery. The comprehensive scope of services offered by these PCGs, from in-home continuing care to other forms of specialty care, will also serve a wide range of the patient-client populations.

Recommendation 6: PCGs, managed by a member (or members) of a regulated health profession (i.e. physicians, nurses, pharmacists, etc.), would consist of a minimum of 3-5 primary care physicians along with an integrated team of health professionals. This would allow for the provision of comprehensive and accessible care; 24 hours a day, seven days a week.

4.4 The Future of Home Care Delivery

While one financing option for home care is to continue to fund organizations charged with the distinct responsibility to negotiate, select, approve, and evaluate (internal or external) contractual arrangements with home care providers, this financing option does not address the fundamental need for service integration. Hence the current financing, organization and delivery of post-acute home care and in-home continuing care in Ontario is in need of reform.

The contemporary landscape of health care is one in which coalitions of people, places, and technologies are configured to suit the individualized needs of care recipients. However, such health care coalitions are achieved despite, not because of, the contemporary institutions of health care. The development of another separate program, another set of vested interests, would do little to further the interests of Canadians who desire the formation of individualized configurations of health care services and settings. Consequently, if fundamental health reforms are to occur, financing has to follow the care recipient, and in the case of post-acute home care (PAHC) this implies that financing should be first directed to hospitals, and for in-home continuing care, financing should be directed to PCGs. The primary care model discussed in this paper focuses specifically on the integration of in-home continuing care into the PCG model.

Recommendation 7: Financing for post-acute home care (PAHC) should be directed to hospitals, and funding for in-home continuing care should be directed to PCGs. However, the home care envelope should be monitored on a regular basis to ensure the appropriate provision of such care.

4.5 Patient-Client Choice

To implement a capitation payment scheme that incorporates a case-mix adjusted capitation fee, individual patients-clients would need to roster with a primary care group. Based on the number and type of roster patients, such organizations would receive public funding for the provision of primary health care services. To generate competition for patients-clients and to ensure that public funds "follow patients", patients-clients must have the opportunity to freely choose their PCG. While patients who are disgruntled with the quality of care offered by a particular PCG may take their business (and their capitation fee) elsewhere, this response only represents the exit dimension to patient choice. Clearly, other mechanisms that enhance the provision of quality care should also be pursued.

Recommendation 8: We recommend that patients-clients be granted the opportunity to roster with a single PCG of their choosing.

Recommendation 9: We recommend that patients have the option to terminate their agreement with a PCG and roster with a different PCG of their choice.

5.0 The Cost of Primary Care Groups

In this section, we estimate the cost of primary health care organized through use of Primary Care Groups (PCGs). In order to expand the principle of comprehensiveness embedded in the *Canada Health Act* to the range of primary health care services discussed in this report, expenditure estimates are required. Since any estimate is fraught with a series of underlying assumptions that may prove to be untenable in various circumstances, the estimates derived in this Section should be viewed as a first approximation to inform the policy decision-making process. Before implementation, more complete estimates are required.

Estimates of the cost of the proposed model of primary health care reform outlined in this report are derived in four stages. First, building on the estimates derived for the Senate (Coyte, 2002), we estimate current expenditures on in-home continuing care services. Second, we estimate the portion of Ontario Health Insurance Plan expenditures associated with the provision of primary care physician services. Third, we measure the publicly funded cost of drugs that are currently available to seniors and the indigent, and finally, we estimate the laboratory and diagnostic service costs that might be included in the capitation fee payable to primary care groups.

5.1 In-Home Continuing Care

Publicly funded home care expenditures are budgeted at $1.16 billion for fiscal year 2003. To identify the component of such expenditures associated with the provision of in-home continuing care, we use methods reported elsewhere (Coyte, 2002). All home care recipients were assessed and assigned to various categories based on their use of home care in relations to any episode of hospital care. If home care recipients received home care within 30 days of hospital discharge (either inpatient or same day surgery) and if these care recipients did not have home care within the 30 days prior to hospitalization, then such care recipients may be defined as recipients of post-acute home care. Estimates of the magnitude of post-acute home care ranged from 26.5% of total home care expenditures to 42.8% of home care clients. Accordingly, the corresponding estimates for in-home continuing care range from 57.2% of home care clients to 73.5% of home care expenditures.

Two estimates are offered for the proportion of publicly funded home care expenditures attributable to in-home continuing care. The first (and low) estimate is based on the proportion of home care recipients that received in-home continuing care, while the second (and high) estimate is based on the proportion of *expenditures* attributable to such care. While 57.2% of home care recipients received in-home continuing care, 73.5% of total home care expenditures were attributable to such care. Use of both low (57.2%) and high (73.5%) estimates for the cost of in-home continuing care recognizes the uncertainty associated with developing cost estimates.

Thus, estimates of the cost of in-home continuing care for fiscal year 2003 range from a low of $663.5 million to a high of $852.6 million.

5.2 Primary Care Physician Services

While the budget set for the Ontario Health Insurance Plan (OHIP) for fiscal year 2003 is $6.7 billion, only a component of those expenditures are associated with the provision of primary care physician services. Using figures for fiscal year 2002 (Ontario Medical Association, 2004), approximately 78% of total OHIP expenditures were directed to fee-for-service physicians and of those billings only 36.1% were assigned to general practitioners. Applying these shares to budgeted expenditures for fiscal year 2003, and including other expenditures to Ontario-based physicians who were paid in ways other than through Alternative Payment Plans (APPs), estimates of the total expenditure on primary care physician services amount to $2,188.1 million.

5.3 Prescription Drug Coverage for Seniors and the Indigent

Prescription drug coverage for seniors and the indigent is currently available to residents of Ontario. Coverage includes both an annual deductible and fees at the point of utilization. For fiscal year 2003, the Ontario government budgeted $2.3 billion for drug programs that includes programs that depend on a resident's age, income status, pharmaceutical expenditures and medical need.

5.4 Diagnostic and Laboratory Services

Expenditures on diagnostic and laboratory services that are based on referral by a primary care provider may be approximated by the share of laboratory services attributable to such providers in OHIP expenditures. With approximately 8.2% of OHIP expenditures attributable to laboratory expenditures (Ontario Medical Association, 2004), the portion of such expenditures attributable to the provision of primary care is estimated to be $198.3 million. This is based on the product between the estimated share of primary care physician services in total physician services, 36.1% (=$2,188.1 million/ $6,063.5 million), and total laboratory expenditures.

5.5 Calculation of the Capitation Payment

In order to determine the average capitation payment for each Primary Care group, we need to combine estimates from Statistics Canada of the population of Ontario (Statistics Canada, 2003a and 2003b) with the cost estimates derived in Sections 5.1 through 5.4. These costs estimates suggest that total expenditures on primary health care services, excluding drugs, amount to between $3,049.9 and $3,239.0 million. If all drug program expenditures were also included, this figure increases by a further $2,300 million. In fiscal year 2003, the annual per capita cost of publicly financed primary health care services offered to Ontario residents by an array of distinct health care organizations and programs amounted to between $249.21 and $264.66, if drugs were excluded. These costs would increase by a further $187.93 if drugs were included.

While the figures derived in this Section highlight the cost of service provision by an array of geographically separate and organizationally distinct funding program, significant incentives are urgently needed to move ahead with the reform options. Incentives are needed to encourage the formation of Primary Care Groups (PCGs) and to ensure that they are comfortable with the responsibility to manage a pool of resources in order to offer roster patients-clients a range of services delivered by an integrated team of health care professionals. To ensure a smooth transition to PCGs, incentives are needed to move toward group based practice; a range of integrated services; and to ensure management systems to coordinate resources and provide services in a coordinated manner. These reforms are not costless, but the resulting expenditures might best be seen as an investment in the future health of Ontarians. While it is difficult to gauge how much investment is needed to stimulate reform and a smooth transition to PCGs, one thing is certain that the absence of increased funding is certain to result in stalemate.

Recommendation 10: We recommend that funding for a comprehensive range of primary health care services provided by a single organizational entity be 25% larger than the current level of funding to ensure rapid transition towards the formation of PCGs.

Based on current estimates associated with the provision of a comprehensive range of primary health care services, and our recommendation that a further investment of funds need to occur to advance the reform process, the total annual payment to each PCG formed by five primary care physicians and an integrated team of health professionals will be approximately $3.4 million. This envelope would ensure funding on a capitation basis for each of the approximately 6,000 roster patients-clients,[d] or approximately $566 per client (in fiscal year 2003 dollars) in return for the provision of a comprehensive range of primary care services, including in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

Recommendation 11: We recommend that PCGs receive an annual fee of $566 per roster patient (in fiscal year 2003 dollars) in return for the provision of a comprehensive and accessible range of primary health care services, including in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

Based on the recommendations developed in this report, and on the population estimates for Ontario, the total cost of comprehensive primary health care reform in which health care is offered by integrated teams managed by primary care groups and reimbursed on a capitation basis would amount to just under $7 billion annually. While this figure is equivalent to the total OHIP expenditures, it includes expenditures that previously was captured by the Drug Programs and it results in a significant redirection of primary health care for Ontario. Specifically, it yields incentives that further health service integration, it helps to broaden the comprehensive principle

[d] Since there are just over 10,200 active family medicine physicians in Ontario (CIHI, 2002), the average solo practice would have approximately 1,200 patients-clients and the average practice with five physicians would have 6,000 roster patients-clients,

captured under the *Canada Health Act* to include necessary health care wherever that care is sought, delivered and received, and finally, it incorporates mechanisms that help to constrain government liabilities.

6.0 Conclusion and Recommendations

In this Section, we summarize our model of comprehensive primary care reform that is guided by three overarching principles: (1) limiting government liability; (2) integrating health services; and (3) providing a comprehensive range of health care to the patient population.

Issues addressed by our model for comprehensive primary care reform include: reimbursement alternatives for health professionals; organizational change; service integration; and patient-client choice. The Kilshaw report (ACHHRS, 1995), focused on the first set of issues, while Leatt *et al.* (1996) concentrated on the issue of organizational change. Our model is similar to that proposed by the Health Services Restructuring Commission (1999), however, we offer a more comprehensive model for health reform which includes the provision of in-home continuing care services.

We recommend that publicly financed capitation payments be made to PCGs who would then be held clinically and fiscally responsible for the provision of an array of primary care services, including diagnostic, home care and specialty care. Adoption of a capitation payment scheme encourages the vertical and horizontal integration of health care organizations so that the financial risks to health care groups are minimized. First, vertical integration would be a result of establishing selective contracts for the provision of specialty services, and/or home care. Second, horizontal integration, would result in the formation of group practices or physician coalitions, which generate large risk pools of roster patients, thereby reducing financial risks by introducing greater predictability into patterns of health service utilization (Gabel & Redisch, 1979). These modifications in the way in which health care is organized and delivered will affect system performance and resource allocation decisions.

Our proposed model for funding, reimbursement, and delivery provides PCGs with opportunities to negotiate service contracts on behalf of their clients with the most cost-effective health providers. Some of these services might be provided in-house, while others would be based on contractual agreements between the PCGs and other service suppliers (i.e. in-home care providers). Such arrangements enhance health system competition, and moreover, yield price and outcome signals for both performance appraisal and resource allocation decisions.

Finally, one of the main objectives in comprehensive health reform was to ensure the provision of health care services that were responsive to patient-client choice. To ensure public funds "follow patients", patients must be given the opportunity to choose where they may receive their health care services. This objective of patient-client empowerment is achieved by allowing roster patients to terminate their arrangements at any time with one primary care organization and to roster with another of their choice.

Our model for comprehensive primary care reform provides for client choice, and it enhances health system competition, efficiency and quality. Managed by a regulated health professional, the comprehensive scope of services offered by PCGs will serve a wide range of needs in the patient population As such; it represents a useful reform option for the provision of comprehensive and cost-effective health care services that are responsive to patient-client choice.

The following recommendations are aimed to enhance primary care delivery and service integration. This will ensure that Canadians have necessary health care, irrespective of where such care is sought, delivered or received:

Recommendation 1: We recommend limiting government liability by implementing a fixed funding envelope for Primary Care Groups (PCGs). This envelope should provide funding for a comprehensive range of primary care services offered by each PCG including in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

Recommendation 2: Reimbursement for PCGs should be structured according to a risk-adjusted capitation method of payment.

Recommendation 3: Obstacles to the in-house provision of allied health services by PCGs should be removed.

Recommendation 4: Mechanisms should be designed to facilitate the development of contractual arrangements between PCGs and specialty care providers, including in-home continuing care providers, community pharmacists and diagnostic service providers.

Recommendation 5: Contractual agreements concerning price and outcome expectations negotiated between PCGs and speciality care providers, including in-home continuing care providers, community pharmacists and diagnostic service providers, should be subject to public scrutiny.

Recommendation 6: PCGs, managed by a member (or members) of a regulated health profession (i.e. physicians, nurses, pharmacists, etc.), would consist of a minimum of 3-5 primary care physicians along with an integrated team of health professionals. This would allow for the provision of comprehensive and accessible care; 24 hours a day, seven days a week.

Recommendation 7: Financing for post-acute home care (PAHC) should be directed to hospitals, and funding for in-home continuing care should be directed to PCGs. However, the home care envelope should be monitored on a regular basis to ensure the appropriate provision of such care.

Recommendation 8: We recommend that patients-clients be granted the opportunity to roster with a single PCG of their choosing.

Recommendation 9: We recommend that patients have the option to terminate their agreement with a PCG and roster with a different PCG of their choice.

Recommendation 10: We recommend that funding for a comprehensive range of primary health care services provided by a single organizational entity be 25% larger than the current level of funding to ensure rapid transition towards the formation of PCGs.

Recommendation 11: We recommend that PCGs receive annually on average about $566 per roster patient in return for the provision of a comprehensive and accessible range of primary health care services, including in-home continuing care, prescription drug coverage for seniors and the indigent, and possibly, diagnostic and laboratory services.

REFERENCES

Ade C, Henke K-D. (1991). Medical Manpower Policies in the Federal Republic of Germany. Report commissioned by the Federal/Provincial/Territorial Conference of Deputy Ministers for the Project "Toward integrated medical resources policies for Canada".

Advisory Committee on Health Human Resource Services (ACHHRS). (1995). A Model for the Reorganization of Primary Care and the Introduction of Population-based Funding. The Kilshaw Report.

Alter DA, Naylor, CD, Austin P, Tu JV (1999). Effects of Socioeconomic Status on Access to Invasive Cardiac Procedures on Mortality after Acute Myocardial Infarction. New England Journal of Medicine; 341:18, 1359-67.

Barer ML, Evans RG, Labelle RJ. (1988). Fee Controls as Cost Controls: Evidence from the Frozen North. Milbank Memorial Fund Quarterly; 66:1, 1-64.

Birch S, Goldsmith L, Makela M. (1994). Paying the Piper and Calling the Tune: Principles and Prospects for Reforming Physician Payment Methods in Canada. McMaster University Centre for Health Economics and Policy Analysis Working Paper 94-16.

Boulet J-A, Grenier G. (1978). Health Expenditures in Canada and the Impact of Demographic Changes on Future Government Health Insurance Program Expenditures, Economic Council of Canada: Ottawa.

Canadian Bar Association Task Force on Health Care (1994). What's Law Got To Do With It? Health Care Reform in Canada, Ottawa: Canadian Bar Association.

Canadian Institute for Health Information (1998a): Total Health Expenditure by Use of Funds, Ontario, 1975-1998: www.cihi.ca/facts/onthe.htm, November 1998.

Canadian Institute for Health Information (1998b): Population by Province/Territory and Canada, 1975-1998: www.cihi.ca/facts/heappend.htm, November 1998.

Canadian Institute for Health Information (2002): Health Professional, Southam Medical Database, http://secure.cihi.ca/cihiweb/en/AR14_2002_tab4_e.html

Canadian Institute for Health Information (2003). National Health Expenditure Trends: 1975-2003. Ottawa: Canadian Institute for Health Information.

Canadian Medical Association (1993): Towards a New Consensus on Health Financing in Canada, Policy Position Paper, Working Group on Health System Financing in Canada, July, 1993.

Canadian Medical Association: Health Financing in Canada: Meeting the Challenges of Change, Policy Position Paper, Working Group on Health System Financing in Canada, May, 1994.

Coyte PC. (1995). Review of Physician Payment and Service Delivery Mechanisms. Ont Med Rev; 62:4, 23-37.

Coyte PC, McKeever P (2001a). Home care in Canada: Passing the buck. Canadian Journal of Nursing Research, 33:2, 11-25.

Coyte PC, McKeever P (2001b). Submission to the Standing Senate Committee on Social Affairs, Science and Technology: Study on the State of the Health Care System of Canada. The Kirby Committee Submission in October 2001.

Coyte PC (2002). Expanding the Principle of Comprehensiveness from Hospital to Home. Submission to the Senate Committee on Social Affairs, Science and Technology: Study on the State of the Health Care System of Canada. The Kirby Committee. July, 2002

Dunlop S, Coyte PC, McIsaac W (2000). Socio-Economic Status and the Utilization of physicians' Services: Results from the Canadian National Population Health Survey. Social Science and Medicine, 51:1, 123-133. 2000.

Evans RG. (1974). Supplier-Induced Demand: Some Empirical Evidence and Implications, in Perlman, M, (eds) The Economics of Health and Medical Care, MacMillan: New York.

Federal/Provincial/Territorial Working Group on Home Care: A Working Group of the Federal/Provincial/Territorial Subcommittee on Long Term Care. (FPT Work Group) (1990). Report on Home Care. Health Services Promotion Branch, Health and Welfare Canada, Ottawa.

First Ministers of Canada (2003). *2003 First Ministers' Accord on Health Care Renewal*. Canada, 2003.

Gabel JR, Redisch MA. (1979). Alternative Physician Payment Methods: Incentives, Efficiency, and National Health Insurance. Milbank Memorial Fund Quarterly; 57(1), 38-59.

General Accounting Office (1991). Canadian Health Insurance: Lessons for the United States, Report to the Chairman, Committee on Government Operations, House of Representatives, General Accounting Office: Washington, D.C.

Haslam R, Walker N. (1993). Alternative Funding Plans: Is There a Place in Academic Medicine? Can Med Assoc J; 148(7): 1141-1146.

Health and Welfare Canada (1990). National Health Expenditures in Canada 1975-1987. Ottawa, 1990.

Health Canada (1994): Changes in Payment Schedules to Provincial Medical Care Insurance Plans, Health Policy and Consultation Branch, Ottawa: Health Canada, July 1994.

Health Canada (1997): National Health Expenditures in Canada, 1975-1996, Policy and Consultation Branch, Ottawa: Ministry of Supply and Services Canada, June, 1997.

Health Canada (2001). Health expenditures in Canada by age and sex 1980-81 to 2000-01. Health Policy and Communications Branch, Health Canada: Ottawa, August, 2001.

Health Services Restructuring Commission (Duncan Sinclair, Chair). (1999). Primary Health Care Strategy – Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health, Government of Ontario.

Hollander M (1994). The costs, and cost-effectiveness of continuing care services in Canada. Queen's-University of Ottawa Economic Projects Ottawa,1-113.

Hollander MJ. (1999). Substudy 1: Comparative analysis of home care and residential care services: Preliminary findings. National Evaluation of the Cost-Effectiveness of Home Care, Centre on Aging, University of Victoria.

Hurst J. (1991). Reforming Health Care in Seven European Nations. Health Aff; 10(1), 7-21.

Jacobs P, Hall E, Henderson I, Nichols D (1995). Episodic acute care costs: Linking inpatient and home care. Canadian Journal of Public Health, 86: 200-205.

Kenney GM (1991). Understanding the effects of PPS on Medicare home health use. Inquiry, 28: 129-139.

Kenney GM (1993). How access to long-term care affects home health transfers. Journal of Health Politics Policy and Law, 83: 412-414.

Keating, N., *et al* (1999). Eldercare in Canada: Context, content and consequences. Catalogue #89-570-XPE. Ottawa: Statistics Canada.

Kirkman-Liff BL.(1990). Physician Payment and Cost-Containment Strategies in West Germany: Suggestions for Medicare Reform. J Health Politics, Policy and Law; 15: 69-99.

Kristiansen I, Mooney G.: Remuneration of GP Services (1993). Time for More Explicit Objectives? A Review of the Systems in Five Industrialized Countries. Health Pol; 24: 203-212.

Lamarche P, Beaulieu M-D, Pineault R, Contandriopoulos A-P, Denis J-L, Haggerty J (2003) Choices for Change: The Path for Restructuring Primary Care Services in Canada. Canadian Health Services and Policy Research, November 2003.

Laporte A, Croxford R, Coyte PC (2002). Access to home care services The role of socio economic status. Presentation at the Canadian Health Economics Research Association Conference, Halifax, May.

Leatt P, Pink GH, Naylor CD. (1996). Integrated Delivery Systems: Has Their Time Come in Canada? Can Med Assoc J: Mar 15; 154 (6):803-9.

Manga P. (1978). The Income Distribution Effect of Medical Insurance in Ontario, Occasional Paper No. 6, Ontario Economic Council: Toronto.

McIsaac WJ, Goel V, Naylor CD. (1993). The Utilization of Physician Services in Ontario by Adults: Results from the Ontario Health Survey. Institute for Clinical Evaluative Sciences, Working Paper No. 20, October.

McKeever P, Coyte PC (2002). Here, there and everywhere. University of Toronto Bulletin, A16, March 25.

Morrisey MA, Sloan F, Valvona J (1988). Shifting Medicare patients out of hospital. Health Affairs, 7:5, 52-64, 1988.

Neu CR *et al* (1986). Extending the Medicare prospective payment system to posthospital care: Planning a demonstration. R-3335-HCFA, Santa Monica, Rand Corp., 1986.

Ontario Medical Association (2004), Economics, Personal Communication.

Pauly MV, Satterthwaite MA. (1981). The Pricing of Primary Care Physicians' Services: A Test of the Role of Consumer Information. Bell J Econ; 12:2, 488-506.

Parr K (1996). The cost effectiveness of home care: A literature review. Health Services Utilization and Research Commission, Saskatoon, Saskatchewan.

Price Waterhouse: Operational Review of the Ontario Home Care Program, Final Report, Toronto, 1989.

PriceWaterhouseCoopers (1999). Health insider: An indepth research report on consumer health issues. Toronto.

Rodwin VG. (1989). New Ideas for Health Policy in France, Canada, and Britain, in Field, MG, (eds) Success and Crisis in National Heath Systems: A Comparative Approach, Routledge: New York.

Romanow R (2002): Building on Values: The Future of Health Care in Canada 2002.

Saskatchewan Health Services Utilization and Research Commission (SHSURC). (1998). Hospital and home care study. Saskatoon, Saskatchewan Health Services Utilization and Research Commission, Report No. 10.

Senate Standing Committee on Social Affairs, Science and Technology (2002): The Health of Canadians 2002.

Statistics Canada (2000): Canadian Population by Sex and Age, and Population Projections: http://www.Statcan.ca/english/Pgdb/People/Population

Statistics Canada (2001): Population Projections by Age and Sex, 2001. http://www.statcan.ca/english/Pgdb/People/Population/demo23a.htm.

Statistics Canada (2003a): Population by Age and Sex, 2003. http://www.statcan.ca/english/Pgdb/demo10a.htm.

Statistics Canada (2003b): Population by Age and Sex, 2003. http://www.statcan.ca/english/Pgdb/demo31a.htm

Stoddart GL, Barer ML.(1991). Toward Integrated Medical Resource Policies for Canada: 6. Remuneration of Physicians and Global Expenditure Policy. Can Med Assoc J; 147:1, 33-38.

Weissert W, Wan T, Livieratos BB, Pellegrino J (1980). Effects and costs of day-care services for the chronically ill. Medical Care, 28:6, 567-584.

Weissert W. (1985) Seven reasons why it is so difficult to make community-based long-term care cost-effective. Health Services Research, 20:4, 423-433.

Weissert W. (1991). A new policy agenda for home care. Health Affairs, 10:2, 67-77.

Williams AM. (1996) The development of Ontario's Home Care program: A critical geographical analysis. Soc Sci Med; 42: 937-948.

Wilson K, Rosenberg M (2003) Accessibility and the Canadian Health Care System: Squaring Perceptions and Realities. Health Policy; 67:2, 137-148.

Woodward RS, Warren-Boulton F. (1984). Considering the Effects of Financial Incentives and Professional Ethics on "Appropriate" Medical Care. J Health Econ; 3:3, 223-237.

APPENDIX

Table 1

Various Categories and Percentage Distribution of

Canadian Health Expenditures

	1975	1985	2003
Hospitals	44.7	40.8	30.0
Other Institutions	9.2	10.3	9.5
Physicians	15.1	15.2	12.9
Other Professionals	9.0	10.4	11.9
Pharmaceuticals	8.8	9.5	16.2
Capital	4.4	4.1	4.6
Other Expenditures	8.8	9.7	14.9

Source: CIHI (2003): National Health Expenditure Trends, 1975-2003. Canadian Institute for Health Information: Ottawa, 2003.

Table 2

Trends in Canadian Health Expenditures

	1960	2003	Average Annual Rate of Growth
Health Expenditures (in millions of dollars)	2,141.70	121,430.80	9.8%
Per Capita Health Expenditures (in dollars)	119.59	3,839.14	8.4%
Consumer Price Index (Base 100 in 1992)	18.50	122.3	4.5%
Real Health Expenditures (in millions of 1992 dollars)	11,576.76	99,289.29	5.1%
Real Per Capita Health Expenditures (in 1992 dollars)	646.43	3,139.12	3.7%

Source: Health expenditure figures for 1960 were obtained from National Health Expenditures in Canada 1975-1987. (Health and Welfare Canada: Ottawa) 1990. The figures for 2003 were obtained from the Canadian Institute for Health Information: National Health Expenditure Trends, 1975-2003. Canadian Institute for Health Information, Ottawa, 2003. The Consumer Price Index figures were obtained from Statistics Canada: Consumer Price Index, 1996 Classification, Annual Average All Items Indexes, Historical Summary: www.Statcan.ca/english/Pgdb/Economy/econ46.htm.

Table 3

Canadian Population (000s), Distribution (%) and Rate of Growth by Age Group

Age Group	2000	2026	Average Annual Rate of Growth
00-64	26,900.1 (87.5%)	28,437.6 (78.6%)	0.2%
65-74	2,135.2 (6.9%)	4,363.5 (12.1%)	2.8%
75-84	1,298.8 (4.2%)	2,459.4 (6.8%)	2.5%
>=85	416.0 (1.4%)	930.1 (2.6%)	3.1%
Total	30,750.1	36,190.6	0.6%

Source:Statistics Canada: Population by Age and Sex, 2001.
http://www.statcan.ca/english/Pgdb/People/Population/demo10a.htm.
Statistics Canada: Population Projections by Age and Sex, 2001.
http://www.statcan.ca/english/Pgdb/People/Population/demo23a.htm.

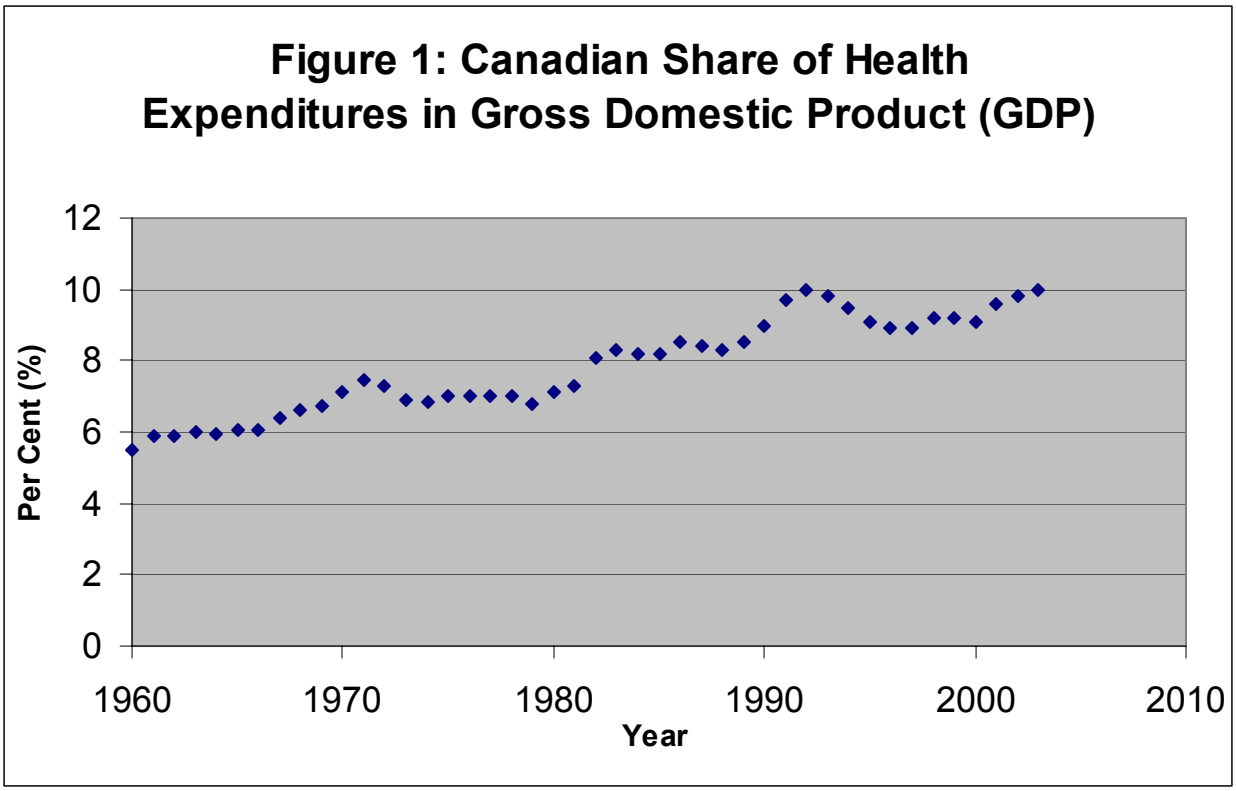
Figure 1: Canadian Share of Health Expenditures in Gross Domestic Product (GDP)
Per Cent (%)
12
10
8
6
4
2
0
1960
1970
1980
1990
2000
2010
Year

Figure 2: Inflation-Adjusted Ontario Government Health Expenditures in Fiscal Year 2003 Dollars

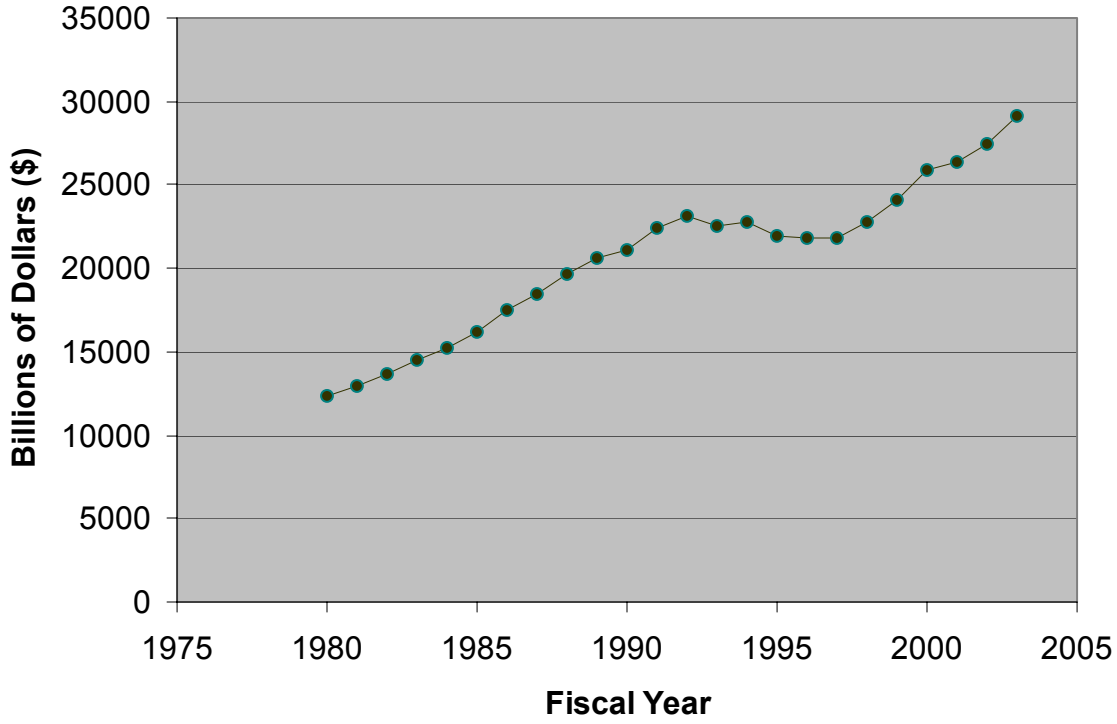

Figure 3: Inflation-Adjusted Per Capita Ontario Government Health Expenditures in Fiscal Year 2003

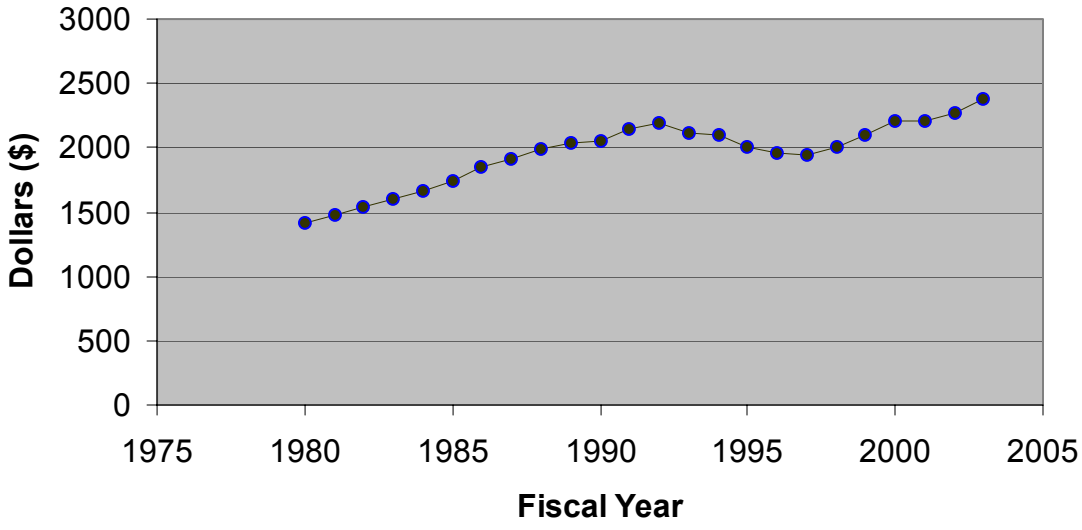

Figure 4: Public Home Care Expenditures in Canada, 1980/81-2000/01

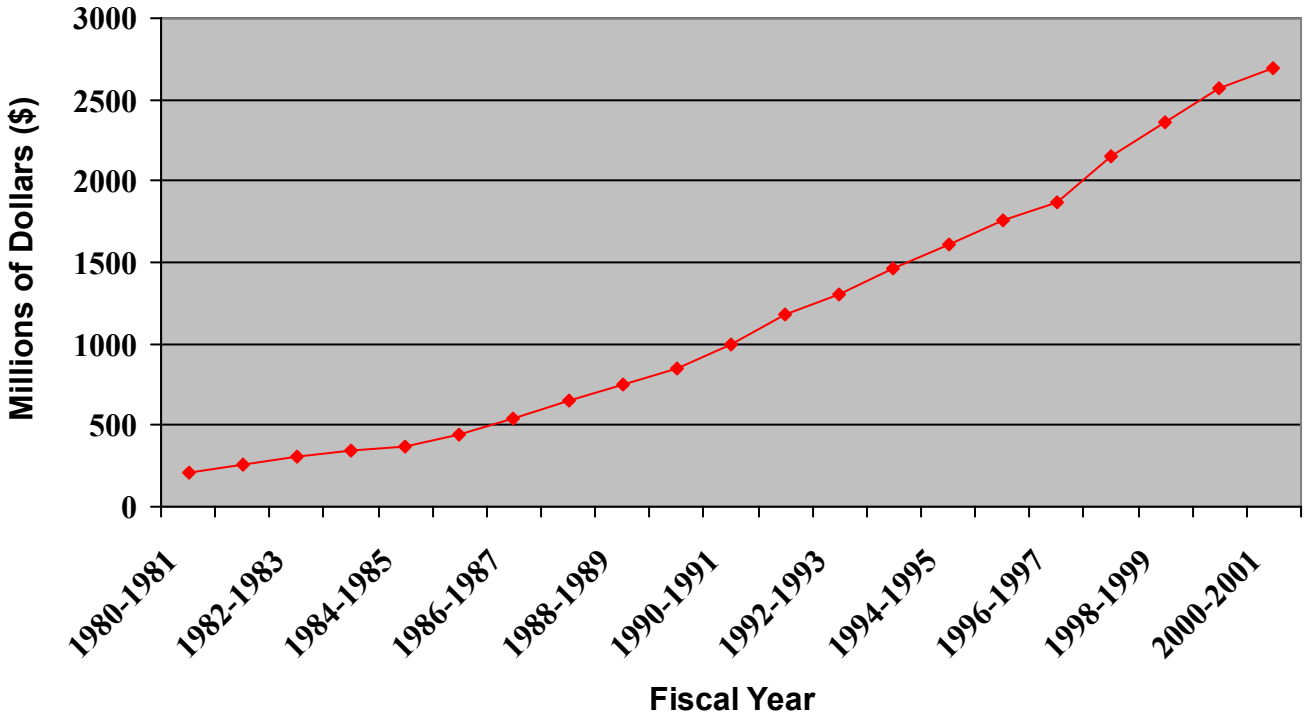

Figure 5: Private Home Care Expenditures in Canada, 1980/81-2000/01