2015 Ontario Health Cut Backs: Overview and Specific Impact on Primary Care

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ABSTRACT

On February 1, 2015, the Ontario government began implementing a series of unilateral cut-backs to health care in Ontario. These changes include a 2.65% decrease to physician fees across-the-board, restricting entry into Family Health Organizations (FHO) and Family Health Networks (FHN), discontinuing enrolment premiums, and restricting the Income Stabilization program. Without a doubt, family physicians are amongst the most heavily impacted physicians. In this commentary, we attempt to summarize the recent events leading to these cut-backs, and discuss the potential implications of these changes in relation to primary care in particular.

RÉSUMÉ

At the time, this contract was supported unanimously by the OMA board and by 81% of physicians in a referendum of Ontario physicians [11]. This PSA expired in March 2014, and for the past year the OMA and the Ontario government have been in negotiations for a new PSA [12].

NEGOTIATION CONFLICTS

The negotiations for the new PSA have been fraught with conflict, partly due to the government’s goal of eliminating the province’s deficit by 2017-2018 [13]. Ontario’s deficit in recent years began with the global economic recession of 2008, which resulted in a provincial deficit of $6.4 billion in the 2008-2009 fiscal year, after three consecutive years of balanced budgets [14]. The subsequent years produced provincial deficits of $19.3 billion in 2009-2010 [15], $14.0 billion in 2010-2011 [16], $13 billion in 2011-2012 [17], $9.2 billion in 2012-2013 [18], and $10.5 billion in 2013-2014 [19]. With the projected deficit for the 2014-2015 fiscal year being $12.5 billion, the new government has inherited a large deficit that must, understandably, be eliminated [13]. Part of reducing this deficit is to reduce government spending, of which healthcare is a major portion.

BACKGROUND

The Physician Services Agreement (PSA) is a contract that is negotiated every few years between the Ontario government and the Ontario Medical Association (OMA), the latter which represents the interests of the approximately 28,000 practicing physicians in Ontario [9]. The PSA is essentially a contract between employer and employee. It details not only how much physicians can bill for various services, but also health care financing on a greater scale, such as where health care funding should be invested, and where we can afford to cut back on certain programs and services. In recent years, the agreement has reflected a careful balance between the government’s responsibility to operate within budget, and physicians’ need for enough financing to serve an aging patient population.

The PSA ratified in 2012 reduced health care expenditures by making changes such as reducing annual health exams, reducing cervical cancer screenings and colonoscopies in accordance with new evidence-based cancer care guidelines, and implementing a 0.5% decrease to physician salaries [10].

Keywords: Family Practice; Family Medicine; Primary Care; Government; Ministry of Health
Following months of negotiations, the government’s final offer to the OMA was a 1.25% increase in budget for physician services. The OMA rejected this offer, citing that this increase would not be enough to cover the increasing healthcare needs of the aging population [12, 20]. Dr. Ved Tandan, president of the OMA, highlighted the fact that “Ontario’s population is already underserviced for health care and our population is growing and aging. That increases the need for health services, but the government has decided to fund less than half of the additional care that will be required” [21].

This argument was refuted by Health Minister Eric Hoskins, himself a family physician, who insisted that physicians would be able to provide the same level of care as before despite the small budget increase proposed. “The OMA wants you to believe that doctors in this province can’t provide the same level of care as last year unless they receive a pay raise and we simply don’t agree…. doctors can’t just bill more and more and more. At some point they’ll have to accept that they can do roughly the same amount of work as last year for roughly the same pay” [21]. Dr. Hoskins further stated that Ontario physicians on average make $360,000 in gross income, suggesting physicians should not complain on reductions to an already-handsome salary [21].

2015 HEALTH CARE CUTS

With both sides unable to come to an agreement after nearly a year of discussion, the government left the negotiations table and announced in January 2015 that it would unilaterally impose a series of health care cuts. The earliest cuts began on February 1st, 2015 with certain changes to become effective at later dates [1, 20, 22].

The new changes are enumerated below [1-7]. Numbers 1-11 impact family physicians directly.

1. **2.65% decrease to all physician payments**
   This is applied to all physicians across the board. It is effective February 1, 2015 for all fee-for-service payments, and May 1, 2015 for other models of payment.

2. **Reconciliation**
   The ministry will impose a hard cap on spending on physician service. If physicians, as a whole, bill more than this amount, money will be taken back from physicians in 2-3 years’ time. It has not been specified as to how these so-called clawbacks would occur.

3. **Discontinue CME program**
   Physicians will no longer be compensated for Continuing Medical Education (CME) activities.

4. **Managed entry into Family Health Networks, Organizations and Teams**
   Previously, 40 new family physicians per month were allowed to join or start a Family Health Network (FHN) or Family Health Organization (FHO). This occurred under two streams - 20 in a priority stream and 20 in a stream that was first-come-first served (based on date of application).

   As of June 1, 2015, only 20 physicians per month will be allowed to join FHO or FHN, and only in areas of high need (priority stream only). By default, new family physicians who do not fulfill these criteria will only be allowed to join a Family Health Group (FHG), start a solo practice under the Comprehensive Care Model (CCM), or bill fee-for-service. The only way for physicians to practice under a FHO or FHN outside of the above parameters is to act as a locum for an existing group, or replace a departing physician (ex. retiring physician) [23].

   Only practices that are under the FHO or FHN model can apply to become a Family Health Team (FHT). Essentially, the only way for a physician to join a FHT is to join the FHO or FHN that has been designated as a FHT. Therefore, by limiting entry into FHO and FHN practices, entry into FHT practices will be limited as well [24].

   FHOs, FHNs and FHTs are considered to provide more comprehensive care than FHGs and CCM because they incorporate a team of allied health professionals. Furthermore, they offer after-hours telehealth advisory services every day of the week. There is evidence that FHOs, FHNs and FHTs are linked to higher patient satisfaction, more patient-centered care, and better learning environments for medical students (this has been one of the reasons more students are choosing family medicine as a career).

5. **Discontinue enrolment premiums**
   These are one-time premiums paid to family physicians for accepting new patients [25]. Exception: There are three enrolment codes that will be continued, and those are for enrolling a patient previously without a family doctor (Q023), a Fecal Occult Blood Test positive patient (Q043), and complex or vulnerable patients from Health Care Connect (Q053).

6. **Discontinue Health Care Connect program**
   This program helps unattached patients find a family physician. The program is currently still in effect; details on its discontinuation are pending.

7. **Restrict Income Stabilization program**
   The Income Stabilization program helps new physicians entering FHN and FHO groups by ensuring stable monthly payments in
their first year of practice, thus acting as a source of financial stability [25]. This program provided around $200 000 - $220 000/year to new family physicians [23].

8. Acuity Modifier - delay
Physicians therefore feel less pressure to speed through appoint
ments. Most recent family medicine residents have been trained
not rely heavily on the number of appointments in a day [25].

9. Reduced fee for weekend or holiday assessment of urgent medical problem (A888)
Physicians therefore feel less pressure to speed through appoint
ments. Most recent family medicine residents have been trained
not rely heavily on the number of appointments in a day [25].

Table 1 for differences between these family practice models).

10. HOCC one time (per diem) payment discontinued
Established family physicians are affected as well. There will be a
2.65% across-the-board cut to all physician services. Recently the
public has been told that Ontario physicians make around $360 000/year. However, this is not the case for most family physi
sicians. The average gross income for family physicians is in the
range of $200 000 to $300 000 [34]. This gross income is used to
pay the overhead costs of their clinic, which include rent, equip-
ment costs, and staff salaries. These overhead costs consume
roughly 30-40% of the gross income, resulting in an average net
income of approximately $175,000 [34, 35]. Reducing the gross
income of family physicians not only affects their net income, but
also may reduce available funding for their clinic and thus, the
quality of patient care [29, 30, 33-38].

Furthermore, while the government insists it won’t limit how
many patients physicians see, there will be a hard cap on the to-
tal amount the government will spend on physicians services. If
physician billings exceed this hard cap, they must pay back the
excess at a later date. Unfortunately, physician billing is often de-
pendent on patient need for health services [30, 31]. Taking back
money from physicians who work above and beyond the average
income of family physicians not only affects their net income, but
also may reduce available funding for their clinic and thus, the
quality of patient care [29, 30, 33-38].

Currently, 900,000 Ontarians do not have a family doctor, and
there are an estimated 140,000 new Ontarians, both newborns
and immigrants, expected over the next year [12]. Unfortunately,
there is a feeling amongst new family medicine residents that
Ontario is no longer an optimal region to practice. Many new On-
tario family physicians may establish themselves elsewhere - per-
haps out of province, or in the United States.

CONCLUSION
Fruitless negotiations between the Ontario government and the
OMA have resulted in the government imposing unilateral cut-
backs to health care in Ontario. Most of these cutbacks affect
family physicians. Channelling new graduates into fee-for-service practices, as well as reducing their starting salaries may encourage them to practice out of province. Furthermore, existing family physicians in Ontario may be faced with difficulty as they try to meet higher patient care demands with decreasing gross incomes.

REFERENCES


3. Memorandum of Agreement between Her Majesty the Queen Right of Ontario, represented by the Minister of Health and Long Term Care and OMA. 2014 Dec 5 [updated 2015 Jan 9].


10. “2012 Physician Services Agreement between OMA and Her Majesty the Queen Right of Ontario, represented by the Minister of Health and Long Term Care”. 2012 Physician Service Agreement. 64 p.


32. “Payments to Ontario Physicians from Ministry of Health and Long Term Care”. 2012 Physician Service Agreement. 64 p.

Commentary


Table 1. [Family Health Models in Ontario]. Description of the differences between types of Family Medicine Practice Models in Ontario

<table>
<thead>
<tr>
<th></th>
<th>Comprehensive model aka Fee for Service</th>
<th>Family Health Team</th>
<th>Family Health Group</th>
<th>Family Health Networks</th>
<th>Family Health Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who it is for</td>
<td>Designed for solo family physicians</td>
<td>Work interdiscipli-</td>
<td>3+ physicians</td>
<td>3+ physicians</td>
<td>3+ physicians</td>
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<td></td>
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<td>nary teams</td>
<td>practicing together</td>
<td>practicing together</td>
<td>practicing together</td>
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<tr>
<td>Hours</td>
<td>Regular office hours + 3h/week extended</td>
<td>Regular and extended</td>
<td>Regular office hours + 3-5 sessions per week extended hours</td>
<td>Regular office hours + 3-5 sessions per week extended hours</td>
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<tr>
<td>Enrolment of Patients</td>
<td>Strongly encouraged</td>
<td>Strongly encouraged</td>
<td>Strongly encouraged</td>
<td>Commit to enrol patients</td>
<td>Commit to enrol patients</td>
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<tr>
<td>Allied Health</td>
<td>Already integral part of this team</td>
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<tr>
<td>After hours service for controlled patients</td>
<td>Variable</td>
<td>Variable</td>
<td>Nurse-staffed, Telephone Health Advisory Service</td>
<td>Nurse-staffed, Telephone Health Advisory Service</td>
<td></td>
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</tbody>
</table>

[A] Blended Capitation: Capitation based on a defined basket of primary care services provided to enrolled patients based on age/sex of each patient. Fee-for-service paid for other services [25].

[B] Blended Salary: Physicians are salaried employees of Community or Mixed Governance Family Health Teams: salary based on number of enrolled patients, plus benefits, bonuses [25].

[C] Complement based model: A base payment for a full-time equivalent “complement” in a given community/geographic area in addition to overhead payments, locum coverage, continuing medical education [25].