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

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].

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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.

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
The acuity modifier is a $40 million/year payment given to physicians who practice under models in which patient enrolment is based on the acuity of patients. Payment for these services will not be delayed for two years.

9. Reduced fee for weekend or holiday assessment of urgent medical problem (A888)
The A888 fee is reduced to from $35.40 to $33.70. This change applies to many family physicians, since this is often what is billed at walk-in clinics [23].

10. HOCC one time (per diem) payment discontinued
The Hospital On-Call Coverage (HOCC) program pays physicians who work on-call at hospitals [26]. The HOCC One Time Payment will be discontinued for HOCC groups < 5 physicians - this is a stipend for working above their minimum call shift requirements.

11. HOCC freeze
Funding for the HOCC program will be frozen. No new HOCC groups/group members will be approved.

12. Chronic Disease Assessment Premiums (E078)
This premium is given for certain physicians who accept complex patients with certain chronic conditions [27]. It will be discontinued for internal medicine, cardiology,
gastroenterology, and nephrology.

POTENTIAL IMPLICATIONS TO PRIMARY CARE

Family physicians are directly impacted in many ways by the recent health care changes. Specifically, new family medicine graduates who are looking to start or join practices are heavily affected.

The restrictions to joining FHO, FHN, and, thus, FHT practices likely arose from the fact that these newer models are more costly than traditional models based on fee-for-service such as CCM and FHG. On average, a FHO costs the government $70 000/year more than a CCM, and $30 000/year more than a FHG [23]. (See Table 1 for differences between these family practice models). The popular FHO, FHN, and FHT models have been touted as the modern way to deliver primary care. Unlike the traditional fee-for-service models, physician income under these models does not rely heavily on the number of appointments in a day [25]. Physicians therefore feel less pressure to speed through appointments. Most recent family medicine residents have been trained under these new models, but for the most part will not be able to join these types of practices once they graduate [28-32]. Even if new family physicians commit to moving to "high need" areas in hopes of joining a FHO, FHN or FHT, they can only do so if the local quota for entry into these models has not been reached. The province-wide limit for joining these models is now only 20/year [23].

The discontinuation of enrolment premiums will affect new graduates as well. It is estimated that new graduates will lose $30 000/year, and that established physicians will lose $5000/year based on this cut alone. This cut affects all new graduates, even those that decide to relocate to high need areas. The discontinuation of the Income Stabilization program, except for in "underserviced areas", will also decrease starting salaries of new graduates. All in all, new family physicians stand to lose $30 000 - $100 000 compared to the starting salaries of their predecessors [23].

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 a year. However, this is not the case for most family physicians. 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, equipment 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 total 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 dependent on patient need for health services [30, 31]. Taking back money from physicians who work above and beyond the average in order to provide for their communities may, at best, be discouraging and, at worst, penalizing to these individuals.

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 Ontario family physicians may establish themselves elsewhere - perhaps 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 cutbacks 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.

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

	Comprehensive model aka Fee for Service	Family Health Team	Family Health Group	Family Health Networks	Family Health Organization
Who it is for	Designed for solo family physicians	Work ininterdisciplinary teams	3+ physicians practicing together	3+ physicians practicing together	3+ physicians practicing together
Hours	Regular office hours + 3h/week extended hours	Regular and extended hours	Regular office hours + 3-5 session per week extended hours	Regular office hours + 3-5 sessions per week extended hours	Regular office hours + 3-5 sessions per week extended hours
Enrolment of Patients	Strongly encouraged	Strongly encouraged	Strongly encouraged	Commit to enrol patients	Commit to enrol patients
Allied Health		Already integral part of this team		Apply to Ministry of Health and Long Term Care to add other health professionals as part of a FHT.	Apply to Ministry of Health and Long Term Care to add other health professionals as part of a FHT.
After hours service for controlled patients	Variable	Variable	Nurse-staffed, Telephone Health Advisory Service	Nurse-staffed, Telephone Health Advisory Service	Nurse-staffed, Telephone Health Advisory Service
Pay	Fee for service	Blended capitation model [A] OR blended salary model [B] OR complement based remuneration [C]	Fee for service	Blended capitation model [A] – age and sex adjusted + bonuses and incentives	Blended capitation model [A] – complement based + bonuses and incentives

[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].