

1.0 Summary

As of March 31, 2016, Ontario had about 30,200 physicians (16,100 specialists and 14,100 family physicians) providing health services to more than 13 million residents at a cost for the year then ended of \$11.59 billion. This is 20% higher than the \$9.64 billion paid to physicians in 2009/10.

Physicians operate as independent service providers and are not government employees. They bill their services to the province under the Ontario Health Insurance Plan (OHIP) as established under the *Health Insurance Act*.

Under the December 2012 Ontario Medical Association Representation Rights and Joint Negotiation and Dispute Resolution Agreement (OMA Representation Rights Agreement), the Ministry of Health and Long-Term Care (Ministry) recognized the OMA as the exclusive bargaining agent of physicians, and both parties agreed, among other things, to consult and negotiate in good faith on physician compensation and related accountability.

The Ministry is responsible for establishing policies and payment models to fairly compensate physicians, while at the same time ensuring that taxpayer funds are spent effectively. Through various divisions with an annual budget of about \$27.9 million and 260 staff, the Ministry adminis-

ters payments to physicians and ensures billings are appropriate. Its Negotiations and Accountability Management Division has the main role in overseeing this billing process.

Physicians in Ontario can bill under three major models:

- The first is a **fee-for-service model** (fiscal year 2015/16—\$6.33 billion) under which physicians are compensated based on a standard fee for each service they perform. They bill using fee codes in OHIP's Schedule of Benefits. This model has been the principal way that physicians bill since 1972. It is widely used today, mainly by specialists.
- The second is a **patient-enrolment model** (fiscal year 2015/16—\$3.38 billion) under which physicians form group practices (such as Family Health Organizations and Family Health Groups) and are paid for the number of patients enrolled with them, and for a predetermined basket of services the group provides to those patients. The objective is for family physicians to offer their patients more comprehensive and continuous care. Remunerations might also include a combination of bonuses, incentives and other payments for additional work including fee-for-service payments for services outside the basket of services. Family physicians could opt into one of the patient-enrolment models

or continue with fee-for-service. This type of model generally allows family physicians to earn more than under the fee-for-service model. As of March 31, 2016, 8,800 out of 14,100 family physicians had opted for one of the patient-enrolment models (Family Health Organizations and Family Health Groups accounted for 92% of the total number of enrolled patients). The remaining family physicians mainly bill fee-for-service or are paid through alternative payment plans.

- The third is **alternative payment plans** (fiscal year 2015/16—\$1.88 billion) and other contracts with hospitals and physician groups to provide specific services. In addition to the \$1.88 billion, approximately \$1.2 billion was paid to alternative-payment-plan physicians as fee-for-service, which is included in the \$6.33 billion paid under the fee-for-service model mentioned above. **Figure 1** provides a breakdown of payments.

Over the last five years, Ontario physicians have been among the highest paid in Canada. While one reason for this is that Ontario has the third-highest population-per-physician ratio, it also compensates more physicians than other provinces with models such as the patient-enrolment model—a more expensive model than fee-for-service. Over the years, physicians were paid additional incentives even after reviews concluded that some of these

payments likely did not improve the quality of patient care. For example, in 2014/15, each family physician in patient-enrolment models received \$3 per patient each month, which cost \$364 million on top of base capitation payments (the fixed amount paid for each enrolled patient, regardless of patient visits or services actually performed).

However, use of patient-enrolment models has still not translated into increased access to care as measured by wait times—57% of Ontarians waited two days or more to see their family physician in 2015/16 as compared to 51% in 2006/07. Ministry survey data for the period October 2014 to September 2015 showed that approximately 52% of Ontarians found it difficult to obtain medical care in the evening, on a weekend or on a public holiday without going to a hospital emergency department.

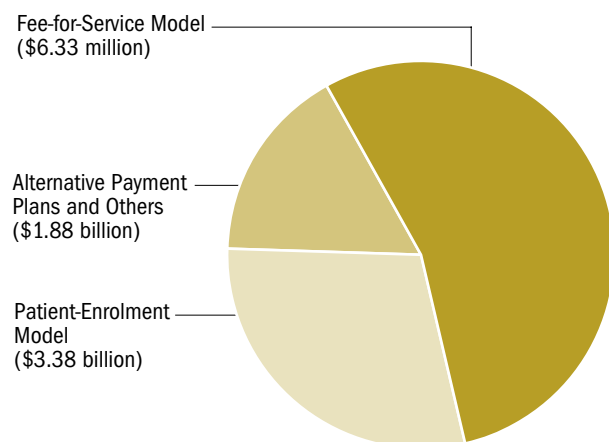
Our review of Ministry data noted that in 2014/15, each physician in a group practice called a Family Health Organization worked an average of 3.4 days per week, while each physician in a group practice called a Family Health Group worked an average of four days per week. In 2014/15, 60% of Family Health Organizations and 36% of Family Health Groups did not work the number of weeknight or weekend hours required by the Ministry. As well, many patients are visiting walk-in clinics for care that could normally be provided by family physicians. The Ministry's survey data for October 2014 to September 2015 showed that approximately 30% of Ontarians had visited a walk-in-clinic in the last 12 months.

The Ministry is also having challenges managing and controlling the use of services billed under the fee-for-service model. One way to achieve some cost savings here is by encouraging physicians, based on clinical research, to reduce medically unnecessary services. However, the Ministry has had limited success with this and in 2015 implemented across-the-board cuts to physician payments, which is not a sustainable way to contain costs.

Another way to manage costs is to adjust fee-for-service rates based on new clinical practices—an area where Ministry attention is still needed.

Figure 1: Payments to Ontario Physicians, 2015/16

Source of data: Ministry of Health and Long-Term Care



Further, the Ministry's oversight and recovery of inappropriate fee-for-service payments is weak and is hindered by its lack of an inspection function and ineffective enforcement of payment recovery mechanisms.

Some of our more detailed findings are as follows:

- **Patient-enrolment models for compensation of family physicians are not meeting original objectives and pose management issues for the Ministry.** There were four objectives when Ontario decided to implement the more expensive patient-enrolment model: to increase patient and physician satisfaction, cost-effectiveness, access to care, and quality and continuity of care.
 - The objective of increasing patient satisfaction with family physicians has been achieved, but at a cost: the Ministry estimates that for the year ended March 31, 2015, physicians were paid for base capitation under Family Health Organizations approximately \$522 million that would not have been paid under a fee-for-service model, in part because physicians were compensated for approximately 1.78 million patients that they had enrolled, but did not treat.
 - Although the number of Ontarians who have a family physician has risen by 43% since 2006/07 (from 7.4 million to 10.6 million in 2015/16), it has not translated into increased access to care as measured by wait times, as previously noted.
 - The Ministry is not able to demonstrate whether patient-enrolment models have improved quality and continuity of care, and its cost-effectiveness evaluations are inconclusive. The Ministry's billing system indicated that 40% of enrolled patients went to walk-in clinics or other family physicians outside the group in which they were enrolled. As well, an estimated 27% of enrolled patients have chronic health conditions and regularly seek primary care outside their physician group, contrary to best practices. This resulted in duplicate payments of \$76.3 million cumulatively over the five years up to fiscal 2014/15. The Ministry does not recover these payments.
- High use is being made of emergency-department services for non-urgent care that could be provided by family physicians. During 2014/15, about 243,000 visits were made to emergency departments for conditions that could have been treated in a primary care setting. The Ministry estimated these visits cost \$62 million, of which \$33 million was incurred by patients enrolled in Family Health Organizations that are compensated using the patient-enrolment model. The Ministry does not recover this money from these patients' family physicians.
- In 2014/15, 1.78 million (or 33%) of the 5.4 million patients enrolled with a Family Health Organization did not visit their family physician at all, yet these physicians still received a total of \$243 million for having them enrolled. Most of the patients who did not visit their physicians were males between the age of 20 and 29.
- **Ministry faces challenges controlling costs under the fee-for-service model.**
 - **Under the 2012 OMA Representation Rights Agreement, the Ministry and the OMA must consult and negotiate in good faith to establish physician compensation.** Fee-for-service claims have been growing at an annual rate of 3.3%, despite the Ministry's targeted rate of 1.25%. In a taxpayer-funded system, the decision to provide a service should be based on whether it is medically necessary—a professional judgment that should also be informed by medical research studies. The Ministry has not been successful in achieving a reduction of medically unnecessary

services. It initiated an across-the-board payment reduction because it did not reach an agreement on future billing amounts and rules with physicians.

- **Ministry does not have the information it needs to assess whether the large variances in gross fee-for-service payments to the same type of specialists are reasonable.** We noted that large variances exist in gross payment per physician (before deduction of office expenses and overhead) within certain specialties. For example, in 2014/15, ophthalmologists at the higher end of the pay range received an average of about \$1.27 million each—close to 130%, or over \$710,000, higher than the approximately \$553,000 received by ophthalmologists in the middle of the pay range. However, the Ministry does not have complete information on physicians' practices and profit margins to help it analyze the disparities.
- **There is a high disparity of gross payment per physician between specialists.** The fee-for-service model in Ontario favours procedural specialists (those who perform procedures such as diagnostic testing or surgery), who also generate a high volume of services. For example, vascular surgeons, who perform on average 12,230 services per year, would be paid an average of \$43 per service, whereas pediatricians average 6,810 services and would be paid an average of \$31 per service. To assess reasonableness, and the impact of technology on service levels, the Ministry needs to obtain more information on physicians' practices, including operating costs and profit margins.
- **Ministry lacks a cost-effective enforcement mechanism to recover inappropriate payments from physicians.** The Ministry has had no inspector function since 2005. Its current recovery process on inappropriate billings is

lengthy and resource-intensive: the onus is on the Ministry to prove that the physicians who bill on the honour system are in the wrong, not on the physicians to prove they are entitled to the billing. Unless a physician repays amounts voluntarily, it is very difficult for the Ministry to recover inappropriate payments. Legislative changes in 2005 established a Physician Payment Review Board. Alberta and British Columbia can order a physician to repay overpayments without an order from a similar board.

- **Ministry does not investigate many anomalous physician billings.** The Ministry did not investigate many instances where physician billings exceed the standard number of working days and expected number of services. We noted that, for example, nine specialists each worked over 360 days in 2015/16; six of these worked 366 days (2016 was a leap year). A further example includes one respirologist who worked 361 days in 2015/16 and billed the province \$1.3 million, close to five times higher than the upper expected limit and billed for close to 12,400 services that year, about four times the upper expected range for the same billing category. Other examples of anomalies:
 - One cardiologist worked 354 days in 2015/16 and billed the province \$1.8 million, which is three times higher than the upper expected limit for physicians in the same billing category (procedural specialists). This specialist provided over 13,200 services that year, 2.4 times the upper range of expected services for physicians in the same billing category.
 - One diagnostic radiologist worked 313 days in 2015/16 and billed the province \$1.7 million, which is 2.8 times the upper expected limit for physicians in the same billing category (diagnostic specialists). This specialist provided over 57,400 services that year, 5.6 times the upper range

of expected services for physicians in the same billing category.

While the Ministry had initiated some investigations on its own, the investigations were not done in a timely manner. For example, one cardiologist billed \$2.5 million during 2014/15 for performing over 68,000 services, more than six times the number of services rendered by the average cardiologist. However, the Ministry had not concluded its investigation at the time of our audit.

- **Ministry does not follow up on many cases of possible inappropriate billings by physicians.** Since the beginning of 2013, the Ministry has not actively pursued recovery of overpayments in proactive reviews; it was recovering approximately \$19,700 in 2014 and nothing in 2013 and 2015. In prior years, recoveries were well over a million dollars. As well, the Ministry no longer follows up on all physicians who have billed inappropriately in the past. This is a concern since in our analysis of 34 physicians who billed inappropriately, 21 had previous instances of inappropriate billing. In addition, the Ministry acknowledged that some specialists are systematically billing one particular code inappropriately. We identified about 370 specialists who were billing this code inappropriately and estimated that between April 1, 2012, and March 31, 2016, the overpayment amounted to approximately \$2.44 million.
- **Ministry has had minimal success in controlling excessive preoperative cardiac testing.** The Ministry targeted savings of \$43.7 million for 2013/14 by reducing the number of unnecessary preoperative cardiac tests, but actual savings were only \$700,000. The Ministry later calculated that for fiscal year 2014/15 alone, approximately \$35 million was paid to physicians for up to 1.15 million preoperative cardiac tests, which may not have been medically necessary, for low-risk surgeries.
- **Concerns of the Ontario Association of Cardiologists (Cardiologists Association) about cardiac-care spending published in an open letter to the Auditor General were reasonable.** The results of our review of the concerns are detailed in this report. In October 2014, the Ministry became aware of fee-for-service claims for two cardiac rhythm monitoring tests that were inappropriately claimed and paid to physicians. The Ministry determined that approximately 70 physicians were overpaid by at least \$3.2 million between April 2012 and May 2015. However, at the time of our audit, the Ministry was not planning to recover any of this amount. In October 2015, the Ministry made the fee for cardiac-ultrasound services the same regardless of whether or not a cardiologist was physically on site. Prior to this, although a cardiologist could have supervised services via telephone or video-conference off site, a cardiologist physically present for the services would have been paid more by being on site. Our review of the Ministry's data for the period October 2015 to March 2016 in comparison to the same prior-year period found that the increase in amount paid by the Ministry and the volume of services conducted was minimal—less than 0.1%. However, we believe that the Ministry should continue to monitor the volume of these services provided to ensure that only necessary services are being conducted with proper supervision.
- **Taxpayers continue to pay significant amounts for the rising cost of physician medical liability protection.** A joint effort between the Ministry, the OMA and the Canadian Medical Protective Association to review the legal context surrounding the dramatic increase in medical malpractice trends is long overdue.

This report contains 14 recommendations, consisting of 29 actions, to address our audit findings.

OVERALL MINISTRY RESPONSE

The Ministry of Health and Long-Term Care (Ministry) is committed to working collaboratively with its partners, making evidence-based decisions with a focus on value and quality for services provided in meeting the needs of Ontarians, and making improvements to sustain the health-care system for generations to come. The Ministry appreciates the comprehensive audit conducted by the Auditor General. The Ministry welcomes the recommendations contained in the report as the Ministry has been limited in its ability to make effective improvements due to the current legislative barriers and negotiations climate. These recommendations will be a significant contribution to support our actions to strengthen accountability and improve access to health-care services.

2.0 Background

2.1 Overview of Ontario Health Care

Since 1972, the Ontario Health Insurance Plan (OHIP) has provided Ontario residents with provincially funded health coverage. OHIP, established under the *Health Insurance Act*, pays for a wide range of health-care services, from visits to a family physician in private practice to hospital surgery performed by a specialist. The Ministry of Health and Long-Term Care (Ministry) funds OHIP, which pays family physicians and specialists (collectively called physicians) for all insured medical services they provide to all eligible Ontarians.

What follows is a summary of the principal players in Ontario health care.

Physicians

Although the services they provide to patients are paid for by the province, physicians are not govern-

ment employees; they operate as independent service providers. As of March 31, 2016, there were about 30,200 physicians in Ontario actively billing OHIP for services rendered. About 14,100 were family physicians, while the remaining 16,100 were specialists in close to 40 different areas of practice, such as cardiology and psychiatry.

It requires at least eight years of post-secondary education and training to become a physician in Ontario, depending on specialty. Family physicians are certified after an examination by the College of Family Physicians of Canada, while specialists must write an examination administered by the Royal College of Physicians and Surgeons of Canada before they can be certified. Upon entering medical practice, physicians recite the Hippocratic Oath, which requires them to preserve all human life, to put the health of their patients first, and to renounce self-interest in the treatment of their patients.

Patients

Ontario's physicians treat the more than 13 million residents eligible for health-care coverage under OHIP. Ontario residents must have a valid OHIP card to receive provincial health-care services at no personal cost. To be eligible for an OHIP card, applicants must be Canadian citizens or have eligible immigrant status, make Ontario their primary place of residence, and have resided in Ontario for at least 153 days in a 12-month period. Patients may choose their physicians. According to Statistics Canada, the percentage of Ontarians aged 65 and over will increase significantly over the next few decades, from 16% in 2015 to over 25% by 2041. About 10% of Ontario's population will be over 80 years old by 2041, compared to only 4% in 2013. This is important, because as people get past a certain age, health-care spending generally increases exponentially.

Ministry of Health and Long-Term Care (Ministry)

The Ministry administers OHIP through several divisions. In the fiscal year ending March 31, 2016,

the Ministry estimated that it has about 260 staff who administer payments to physicians, for a total administrative cost of about \$27.9 million. The Ministry is also responsible for setting policies establishing various payment models to compensate physicians in providing care to Ontarians. It also conducts reviews on physician billings proactively, mainly based on an analysis of billing data, as well as reactively, largely based on complaints it receives.

College of Physicians and Surgeons of Ontario (College)

The College regulates the practice of medicine in Ontario under the *Regulated Health Professions Act, 1991* and the *Medicine Act, 1991*, to protect and serve the public interest. It has the authority to self-regulate the medical profession, and a physician must be a member of the College before he or she can practise in Ontario. The College's duties include physician registration, monitoring and maintaining standards of practice, investigating complaints, and conducting disciplinary hearings.

Ontario Medical Association (OMA)

The OMA was founded in 1880 as a voluntary association to represent Ontario physicians' political, clinical and economic interests. It is governed by a council and a board of directors. The Ministry, through the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement (OMA Representation Rights Agreement) dated December 2012, recognizes the OMA as the exclusive bargaining agent of physicians. Under the agreement, the Ministry and the OMA agreed, among other things, to consult and negotiate in good faith for the purpose of establishing physician compensation for physician services and related accountability in the publicly funded health-care system.

Canadian Medical Protective Association (Association)

Every physician in Ontario is required to obtain and maintain professional liability protection. The Asso-

ciation, a not-for-profit organization, collects membership fees and assists member physicians who face medical-legal difficulties arising from their practice of medicine. It also provides compensation to patients harmed by negligent care. Although they can choose other liability-protection providers, almost all Ontario physicians belong to the Association. The province reimbursed \$237 million, or about 84%, of membership fees that physicians paid the Association in 2015.

The Physician Payment Review Board (Board)

The Board, established in 2010 by the *Health Insurance Act*, is an independent adjudicative tribunal that conducts hearings on billing disputes between physicians and the Ministry at the request of either. As of September 2016, the Board comprises 27 members—11 of them are physicians recommended by the Ministry, another nine are physicians recommended by the OMA, and the remaining seven are public representatives. The Board hears only those payment disputes that cannot be resolved between a physician and the Ministry. After a hearing, the Board may order the physician to reimburse the Ministry if it has concluded that an overpayment was made, or order the Ministry to pay the physicians if it has concluded that an underpayment was made. Since its establishment, the Board has formally heard five cases, all of which were decisions in favour of the physicians.

2.2 Compensation Systems for Physicians

The Ministry compensates Ontario physicians using two broad payment models, as follows.

2.2.1 Fee-for-Service Payment Model

Since the start of publicly funded health care in 1972, the fee-for-service model has been the principal way Ontario physicians bill the province for the services they provide. It is still widely used today, especially by specialists. Under fee-for-service,

physicians are compensated based on a standard fee for each service they perform. The medical services covered and the standard fees payable are detailed in OHIP's Schedule of Benefits, which includes hundreds of fee categories pertaining to over 7,000 fee codes. Although there are hundreds of fee categories, most physicians, especially those with consultation-based office practices, typically bill the same group of five to 10 fees within their specialties because they usually provide the same cluster of services over time. The Schedule of Benefits, laid out under Regulation 552 of the *Health Insurance Act*, also outlines various billing requirements and conditions that must be met before payment is made.

2.2.2 Patient-Enrolment Models

Alternative funding arrangements are any kind of government payments to physicians not made on a fee-for-service basis. For example, instead of receiving a set fee solely for each service performed, physicians might be paid for the number of patients enrolled with them, and for the predetermined basket of services they provide to those patients. Payment might also include a combination of bonuses, incentives and other payments for additional work.

Since the late 1990s, the Ministry began a wide-ranging reform of the primary care system (the part of the medical system that represents the patient's first point of contact with non-specialist, non-emergency care). The reform was meant to address:

- poor and fragmented access to care—a growing number of Ontarians were living longer, including people with multiple chronic illnesses like diabetes, congestive heart failure, osteoporosis and cancer, whose treatment required that they be seen by the same physician over a continuous period of time;
- a lack of communication and information-sharing across the health-care sector;
- financial incentives built into the fee-for-service model that could lead to provision of unnecessary medical services; and

- a shortage of family physicians in Ontario during the 1990s—the OMA noted that there was a shortage of primary care physicians and that primary care was not viewed as a desired specialty by medical students.

Under patient-enrolment models, patients are attached to, and receive primary care from, the same group of family physicians over a continuous period of time. The treatments they receive are intended to be comprehensive rather than based on one-time or occasional needs. **Figure 2** compares the two payment models. Family physicians could opt into one of the patient-enrolment models or continue with fee-for-service.

Since the reform of the primary care system, many family physicians have chosen patient-enrolment models because they could generally earn more than with fee-for-service, and because the models allowed them to offer their patients more comprehensive and continuous care.

As of March 31, 2016, there were about 14,100 family physicians in Ontario, of which 8,800 had opted for one of the patient-enrolment models. **Figure 3** provides a breakdown of the number of family physicians and enrolled patients by model. Most family physicians who opted for patient-enrolment chose either the Family Health Organization or Family Health Group models; together, these two models account for 87% of the 8,800 family physicians in the patient-enrolment model and 92% of the 10.6 million enrolled patients. Most of the remaining family physicians continue to bill OHIP on a fee-for-service basis. Patient-enrolment models include a number of payment types negotiated between the Ministry and the OMA over time. Selected payment types are shown in **Figure 4**.

Payment methods for Family Health Organizations and Family Health Groups are shown in **Figure 5**. In a Family Health Organization, base capitation payments (the fixed amount paid for each enrolled patient, regardless of patient visits or services actually performed), bonuses and incentives account for approximately 80% of a physician's compensation, with the remaining 20%

as fee-for-service. Family Health Groups work the opposite way, with fee-for-service accounting for 80% of compensation, and capitation payments, incentives and other payments accounting for the remaining 20%.

2.3 Payments Made to Ontario Physicians

In 2015/16, Ontario paid about 30,200 physicians a total of \$11.59 billion. About \$6.33 billion of that (55%) was paid on a fee-for-service basis,

Figure 2: Comparison of Patient-Enrolment and Fee-for-Service Models

Source of data: Ministry of Health and Long-Term Care

	Patient Enrolment	Fee-for-Service
Contract-based	Yes. An agreement is signed between the Ministry, a practice of at least three physicians* and the OMA.	No
Patient enrolment	Patients are enrolled with a family physician in a group practice. Patients must agree to seek primary care from that practice.	Not required
Physician practice size	At least three physicians,* although patients enroll with one of the practice's physicians.	Sole practitioner
Compensation structure	<ul style="list-style-type: none"> • Base capitation payment: Amount varies with number and types of bundled services physicians agree to provide to enrolled patients. • Bonus, incentives, premiums and/or other payments: Amount varies with number and types of services physicians perform in specific areas, such as preventive care and diabetes management. • Fee-for-service: Varies with number and types of services physicians perform outside of the basket of services for patients and/or services to patients not enrolled in the practice. 	A fee is paid for each service provided, based on OHIP's Schedule of Benefits.
Treatment focus	<p>Comprehensive and continuous primary care to enrolled patients, including:</p> <ul style="list-style-type: none"> • health assessments; • diagnosis and treatment; • primary reproductive, mental health or palliative care; • support for hospital, home and long-term-care facilities; • service co-ordination and referral; • patient education and preventive care; and • arrangements for 24/7 availability of physician. <p>Management of chronic illnesses like diabetes, congestive heart failure, osteoporosis and cancers that require medical treatment and physician monitoring over a continuous period of time.</p>	Episodes of acute illness with rapid onset that can be resolved in a short period (e.g., colds and flu to strokes) as well as chronic illnesses.

* An exception to the three-physician minimum requirement of the patient-enrolment models is the Comprehensive Care model. As of March 31, 2016, about 400 physicians were billing under this model.

Figure 3: Family Physicians and Patients in Patient-Enrolment Models as of March 31, 2016

Source of data: Ministry of Health and Long-Term Care

Patient-enrolment Model	# of Physician		# of Enrolled Patients	% of Enrolled Patients
	Groups/Practices	# of Physicians		
Family Health Organization	470	5,060	6,560,900	62
Family Health Group	230	2,620	3,156,700	30
Other*	110	1,130	872,700	8
Total	810	8,810	10,590,300	100

* Includes about 10 smaller patient-enrolment models accounting for about 13% of family physicians and 8% of total enrolled patients.

Figure 4: Selected Types of Payments under Patient-Enrolment Models for Family Physicians

Prepared by the Office of the Auditor General of Ontario

Type of Payment	Description
Base capitation payment	Fixed amount paid for each enrolled patient, based on age and sex, for providing services listed in the contract, regardless of the number of services performed or the number of visits by the patient (e.g., for Family Health Organizations ranges from \$62 to \$548 a year per patient).
Access bonus	Approximately 20% of base capitation payment is held back and can be earned by physicians when their enrolled patients do not seek care for the services listed in the contract outside the group with which the patients are enrolled.
Comprehensive-care capitation fee	Fixed amount paid to physicians for each enrolled patient, based on age and sex, for choosing to provide comprehensive care for their enrolled patients.
Complex enrolment fee	Fixed amount paid for enrolling a “hard-to-care-for” patient.*
Enhanced fee-for-service	Physicians are paid an additional 10% more than the Schedule of Benefits amount for the list of fee codes specified in their agreement.
Fee-for-service	Physicians bill OHIP for the established fee per the OHIP Schedule of Benefits for each service provided to a patient.
Incentives	Additional payments to physicians for providing specific services (e.g., patient care on weekends, preventive care and diabetes management); to encourage certain activities (e.g., enrolment of certain types of patients, such as “hard-to-care-for” patients); and for continuing medical education courses.
Shadow billing	An incentive the Ministry provides to physicians on base capitation to submit a record of the services in their predetermined basket of medical services that they have actually performed. Physicians on base capitation can bill OHIP and be paid a percentage of the established fee-for-service amount for patient services listed in the contract; physicians are generally eligible for either shadow billing or enhanced fee-for-service.

* “Hard-to-care-for” patient refers to a patient with complex needs and/or more than one medical condition.

while about \$3.38 billion (29%) was paid through patient-enrolment models. The remaining \$1.88 billion (16%) was paid through alternative payment plans and other contracts with hospitals and physician groups to provide specific services, including physician training, research, emergency and /or other care in hospitals, and working in remote areas. The 2015/16 total is 20% higher than the \$9.64 billion paid to all physicians in 2009/10 (see **Figure 6**). **Figure 7** provides a breakdown of the number of Ontario physicians and associated payments in 2014/15.

Even though the Ministry has been investing heavily in patient-enrolment models, we noted that the amount paid through fee-for-services has also increased by almost 20%, from \$5.33 billion in 2009/10 to \$6.38 billion in 2014/15, primarily

as a result of the increased number of physicians who billed fee-for-service, from about 24,200 in 2009/10 to 28,100 in 2014/15.

The Ministry also reimburses physicians for most of the annual medical liability protection premiums they pay to the Canadian Medical Protective Association. In 2015, that reimbursement was \$237.3 million, or about 84% of the total \$284.3 million in premiums paid.

2.4 The Physician Services Agreement

The Physician Services Agreement (Agreement), negotiated by the Ministry and the OMA, outlines working conditions and remuneration for physicians,

Figure 5: Payment Methods for Selected Patient-Enrolment Models for Family Physicians

Prepared by the Office of the Auditor General of Ontario

Type of Patient-Enrolment Model	Start Date	How Family Physicians Are Paid
Family Health Organization	2006	<p>Base and comprehensive-care capitation fee, shadow billing and incentives for enrolled patients</p> <p>Base capitation fee covers 150 listed services. Shadow billing is paid at 15% of the established fee-for-service value.</p> <p>Physicians also receive additional payments, including:</p> <ul style="list-style-type: none"> • fee-for-service for any service not listed in the contract, and for all services provided to non-enrolled patients; • incentive payments for services such as preventive care, diabetes management, after-hours service and enrolling unattached patients; • complex enrolment fees for “hard-to-care-for” patients*; • \$5,000 to \$15,000 per year for working in a rural community; and • \$12,500 to \$25,000 per year for practices with at least five physicians to help pay for an office administrator.
Family Health Group	2003	<p>Enhanced fee-for-service and incentives for Ministry-assigned patients and enrolled patients, as well as comprehensive-care capitation fees for enrolled patients</p> <p>Enhanced fee-for-service is 110% of the OHIP-listed fee-for-service amount for 33 comprehensive-care listed services. Physicians also receive additional payments, including:</p> <ul style="list-style-type: none"> • complex enrolment fees for “hard-to-care-for” patients*; • incentive payments for services such as preventive care, diabetes management, after-hours services and enrolling unattached patients.

* “Hard-to-care-for” patient refers to a patient with complex needs and/or more than one medical condition.

including the introduction of new compensation models and/or revisions to existing models.

Since 2004, three Agreements have been negotiated between the Ministry and the OMA, with the 2008 agreement providing the highest compensation increases. **Appendix 1** provides a summary of the increases and decreases in physician compensation contained in these Agreements.

The Agreement is generally negotiated every four years, and the last one expired on March 31, 2014. In the absence of an Agreement, the December 2012 OMA Representation Rights Agreement requires the Ministry to follow a specified “Joint Process” which includes consultation and negotiation with the OMA before making any changes that might affect physician compensation. In 2015, after consulting the OMA, the Ministry moved forward with unilateral changes—across-the-board fee cuts of 2.65%

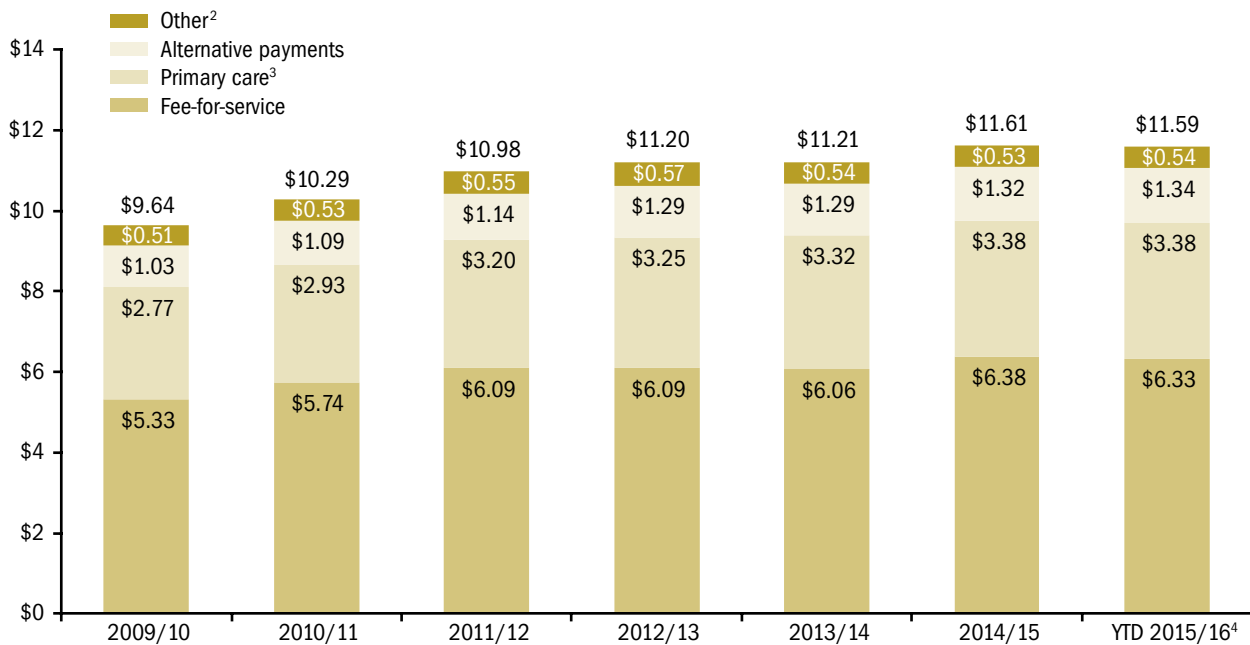
in February and 1.3% in October—even though the OMA did not agree to them. During the period of our audit, therefore, the Ministry and the OMA had no Agreement in place. A tentative settlement was reached on July 7, 2016, which a majority of OMA members rejected in a vote on August 14, 2016.

2.5 Different Physician Compensation Models in Other Jurisdictions

Physician compensation models differ all over the world, and each has its own advantages and disadvantages; there is no one optimal model. As a result, a mixed, blended model approach is most commonly used. Refer to **Appendix 2** for a comparison of prevalent funding models used globally.

Figure 6: Total Expenditures¹ to Ontario Physicians by Type, 2009/10–2015/16 (\$ billion)

Source of data: Ministry of Health and Long-Term Care



Note: A similar breakdown by type is not available prior to fiscal year 2009/10.

1. Excludes the Ministry's payments for Medical Liability Protection.
2. This category is made up of several smaller individual program expenditures to hospitals and/or groups of physicians.
3. Includes fee-for-service expenditures to primary care physicians.
4. The total expenditure for the 2015/16 fiscal year had not been finalized at the time of our audit because the Ministry allows physicians six months to submit their billings for services rendered during that year.

Figure 7: Number of Ontario Physicians and Associated Payments by Payment Type, 2014/15

Source of data: Ministry of Health and Long-Term Care

Total Number of Physicians: 29,410 Total Payments: \$11.61 billion*			
Total # of Family Physicians: 13,710 Total Payments: \$4.17 billion		Total # of Specialists: 15,700 Total Payments: \$6.82 billion	
Patient Enrolment	Fee-for-service and Others	Alternative Payments	Fee-for-service
Physicians: 8,320	Physicians: 5,390	Physicians: 5,970	Physicians: 9,730
\$3.09 billion	\$1.08 billion	\$2.50 billion	\$4.32 billion

* This amount includes approximately \$620 million that the Ministry paid the physicians through other contracts such as for providing on-call services at hospitals.

3.0 Audit Objective and Scope

The objective of our audit was to assess whether the Ministry of Health and Long-Term Care (Ministry) has effective systems and procedures in place to:

- ensure that fees paid to and recovered from physicians are appropriate and in accordance with applicable legislation, regulations and agreements; and
- measure and report on how effectively physician payment models meet the needs of Ontarians.

Senior Ministry management reviewed and agreed to our audit objectives and associated criteria. We conducted our audit fieldwork from October 2015 to May 2016.

Our audit work was conducted primarily at the Kingston and Toronto offices of the Ministry's Negotiations and Accountability Management Division. In conducting our audit, we reviewed relevant documents, analyzed information, interviewed appropriate Ministry staff, and reviewed relevant research from Ontario and other Canadian provinces, as well as jurisdictions in other countries. The majority of our file review went back three to five years, with some trend analysis going back as far as 10 years.

We also reviewed data from the Ministry's information systems on physician billing, and asked the Ministry's Health Analytics Branch to perform certain analyses of this data. As part of the annual audit of financial statements performed by our Office on the Public Accounts of Ontario, we tested key application controls and information technology general controls in the Ministry's medical-claims payment system. We considered the results from that annual financial-statement audit in determining the scope of this value-for-money audit.

We met with representatives of the Institute for Clinical Evaluative Sciences, an independent, not-for-profit corporation that uses Ontario health data to evaluate health-care delivery and outcomes, and relied on some of the data analyses it performed.

In addition, we talked to representatives from stakeholder groups, including the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, and the Physician Payment Review Board, about their perspectives on physician billing and accountability. We discussed legal liability issues with officials from the Canadian Medical Protective Association.

In an effort to better understand the negotiation process and status of the 2014 Physician Services Agreement, we met with the conciliator appointed to assist in advancing the negotiations. We also met with the former legal counsel for the Honourable

Peter deCarteret Cory, who carried out a 2005 review of the Medical Audit System in Ontario, to discuss that review's recommendations. In addition, we engaged a medical professional with knowledge of physician compensation to advise us.

Although we mention the Canadian Medical Protective Association (Association) in our report, we did not have access to its internal data; instead, we relied on available external data and additional information provided to us by the Association and the Ministry. We also relied on physicians employed by the Ministry and our own medical adviser for any interpretations of clinical data.

In June 2016, the Ontario Association of Cardiologists (Cardiologists Association) published an open letter to the Auditor General regarding its specific concerns over cardiac-care spending. (**Appendix 3** contains the letter.) In addition to our audit work already covered in the cardiac-care area, we performed additional work based on the information provided by the Cardiologists Association. The result of our work in this area and additional work to address the Cardiologists Association's concerns is reported in **Section 4.7**.

As part of our planning for this audit, we reviewed the Ministry's January 2013 internal audit report on the review of security controls over the distribution of physician reports containing personal health information, and considered its findings in determining the scope of our audit.

We also asked a selected number of physicians, chosen on a random basis, to complete our survey on their opinions regarding physician billing and compensation as well as the health system overall. About 35% of them responded to our survey.

Finally, we considered the relevant issues reported in our 2011 audit related to patient-enrolment models (see the section entitled **Funding Alternatives for Family Physicians** in our *2011 Annual Report*) and incorporated them into our audit work.

4.0 Detailed Audit Observations

4.1 Ontario Physicians among the Highest Paid in Canada

Over the last five years, Ontario physicians have been among the highest paid in Canada. Data from the Canadian Institute for Health Information shows that the annual average gross clinical payment (payment for health-care services) per physician in Ontario in 2014/15 was approximately \$363,800, just \$2,000 below the highest average payment in Alberta and about \$25,200 above the Canadian average of \$338,600 for the same year. **Figure 8** compares the average gross clinical payment per physician among six provinces with a population of over a million.

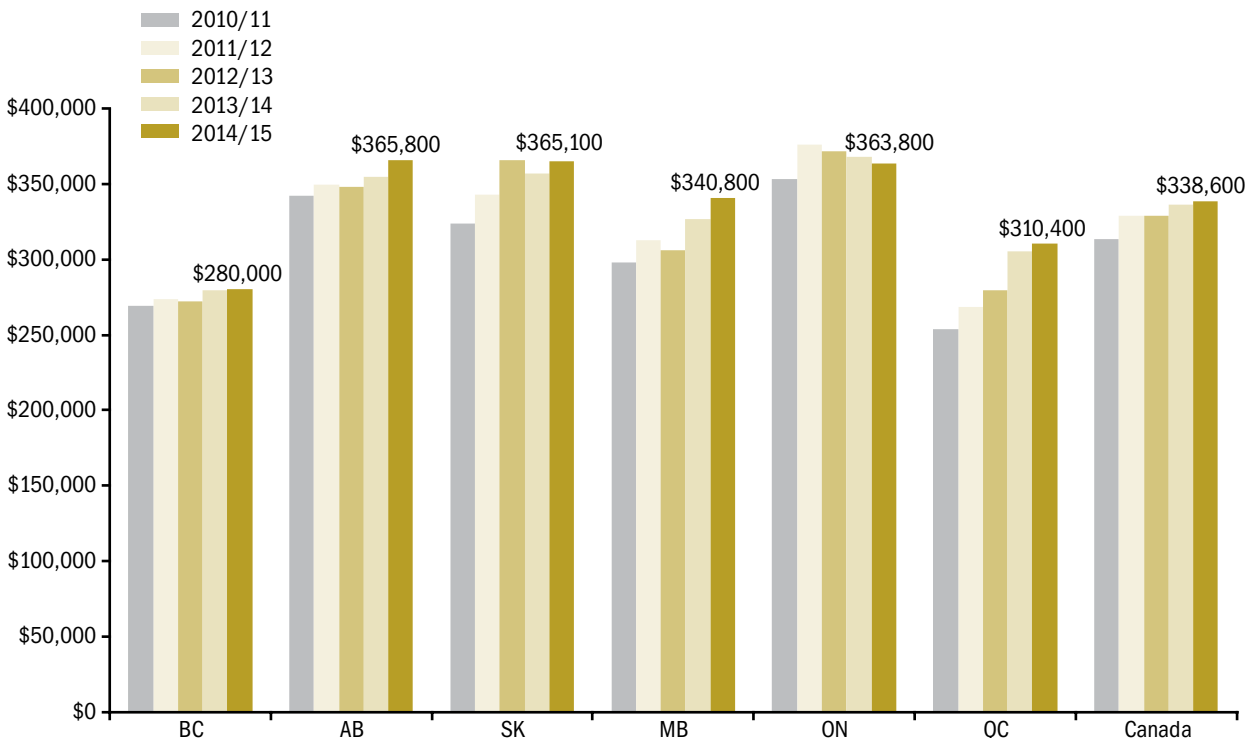
Two main reasons contributed to the relatively high pay physicians receive in Ontario:

- Ontario has the third highest population to physician ratio (**Figure 9**): this leaves each physician with a relatively large number of patients and medical services to bill for.
- Ontario has the largest portion (approximately 36%) of its physician compensation in the form of alternative funding arrangements such as patient-enrolment models. Saskatchewan is second highest at 35%, Manitoba is third highest at 29%, and Alberta is the lowest at 13%. As we explain in **Section 4.2**, physicians earn significantly more in patient-enrolment models than in fee-for-service models.

While about half of the physicians who responded to our survey on billing, compensation and the overall health system indicated that they believe they are reasonably compensated in comparison to their peers within their specialty in Ontario or in other Canadian provinces, the other half disagreed. Some respondents commented that inflation over the last decade has lowered physicians' net income significantly. Many physicians

Figure 8: Average Gross Clinical Payment per Physician, Large Provinces, 2010/11–2014/15

Source of data: Canadian Institute for Health Information



Note: Provinces with population of over 1 million are included. Payments are rounded to the nearest hundred.

Figure 9: Comparison of Population per Physician, Large Provinces and Canada, 2014/15

Source of data: Canadian Institute for Health Information

Province/Canada	Average # of Persons per Physician
Saskatchewan	510
Manitoba	490
Ontario	455
British Columbia	431
Alberta	422
Quebec	414
Canada	439

Note: Provinces with population of over 1 million are included.

expressed that because fees paid to physicians in Ontario are relatively low by Canadian standards, they treat more patients and perform more procedures than physicians in higher-paid provinces, in order to earn about the same compensation. A large number of physicians also stated that patient demand has increased the need for more medical services, and this is a key factor driving the increase in physician billings.

4.2 Significant Investment in Patient-Enrolment Models but Most Objectives Not Met

The patient-enrolment model, when it was introduced as part of the Ministry's primary care reform in the late 1990s, had the following four main objectives:

- Increase access to care;
- Increase quality and continuity of care;
- Increase patient and physician satisfaction; and
- Increase cost-effectiveness.

Our audit found that three of these objectives have not been met, and/or measurable targets have not been set to demonstrate how and to what extent Ontario's population receives better-quality medical care under patient-enrolment models. The Ministry's 2014–15 survey indicates that patients are generally satisfied with interactions with

their family physician (see **Appendix 4**), and this has remained the same over the last three years. However, the Ministry has not recently assessed the satisfaction of primary care providers such as family physicians with patient-enrolment models. When the sample of physicians we surveyed were asked to what extent Ontario needs to change the way physicians are compensated in order to achieve a sustainable health-care system, about 55% said no change or some change was needed, while about 42% said a lot of change was needed or the system should be completely revamped. A small portion, 3%, had no opinion.

The issues primarily surrounding the objectives that have not been met are discussed in the following sections.

4.2.1 Patient-Enrolment Models Significantly More Expensive Than Fee-for-Service Models

In 2014/15, the Ontario government invested approximately \$1.4 billion more in patient-enrolment models than the costs would have been under the traditional fee-for-service model. The additional cost had increased by 55% from \$907.6 million in 2010/11, as shown in **Figure 10**. In March 2016, the Ministry estimated, at our request, the additional cost of the patient-enrolment models for the fiscal year 2014/15. This \$1.4 billion additional cost represented close to 35% of the total OHIP payments to all family physicians in the same year.

Figure 10: Estimated Additional Cost of Patient-Enrolment Models, 2010/11–2014/15

Source of data: Ministry of Health and Long-Term Care

2010/11	2011/12	2012/13	2013/14	2014/15
\$907.6 million	\$1.168 billion	\$1.280 billion	\$1.395 billion	\$1.404 billion

Note: Shows the Ministry's estimate of additional cost over the cost of the fee-for-service model. The Ministry's estimate is based on two assumptions:

1. All family physicians who opted into a patient-enrolment model submitted all their shadow billings to the Ministry; and
2. Physicians' billing pattern and behaviour did not change under patient-enrolment models.

This difference highlights that patient-enrolment models are significantly more expensive than traditional fee-for-service models. According to the Ministry's most recent estimate, in 2014/15, a family physician who belonged to a Family Health Organization earned an annual gross revenue of \$420,600, and one who belonged to a Family Health Group earned an average of \$352,300. Both of these average salaries are significantly higher than the gross billing of \$237,100 physicians would earn, on average, under the traditional fee-for-service model. Yet, the base capitation payments that physicians receive before they actually see any of the patients they enroll were originally designed to be cost-neutral, or about the same as if the services were being provided on a fee-for-service basis.

We noted that for the 2014/15 fiscal year, of the \$1.4 billion additional cost mentioned previously, approximately \$1.1 billion consisted of payments to Family Health Organizations. In that year, the Ministry paid approximately \$1.039 billion in base capitation payments to the family physicians in these organizations. Based on the shadow billing data submitted by the physicians, the total cost of these visits would have been approximately \$517 million if they had been compensated under the fee-for-service model (The \$517 million is an estimate because the calculation assumed that all family physicians who signed up to patient-enrolment models submitted all of their shadow billings to the Ministry. Shadow billing is an incentive the Ministry provides to patient-enrolment physicians who submit a record of the services in their predetermined basket of medical services that they have performed. It is likely that physicians neglected to submit some of these records). The difference of \$522 million is the largest component of the additional cost paid to Family Health Organizations.

The \$522 million is significant, as it indicates that the physicians were not providing core primary care services as often as they should be (or expected to be) and/or that base capitation payments are excessive. We also noted that the \$522 million included base capitation payments for

1.78 million patients who were enrolled but did not visit their physicians in that year (discussed in **Section 4.4.4**). However, the Ministry's view was that if family physicians in the patient-enrolment model returned to billing based on fee-for-service, the volume of their billings might increase to compensate and equalize their income, and the estimated difference of \$500 million might reduce.

The remaining \$600 million of the \$1.1 billion paid to Family Health Organizations (on top of the \$500 million additional cost) consists of other payments such as the comprehensive base capitation payments (discussed in **Section 4.4.3**) and access bonus (discussed in **Section 4.4.2**).

RECOMMENDATION 1

To help ensure that patient-enrolment models are cost-effective, the Ministry of Health and Long-Term Care should review the base capitation payments and make any necessary adjustment in order to ensure that the fees paid are justified for the basket of services physicians actually provide to their enrolled patients.

MINISTRY RESPONSE

The Ministry supports the recommendation and agrees to conduct a review of the capitation rate, including evaluation of the core services provided to patients by physicians who receive a base rate capitation payment. Adjustments to the capitation rate will require the Ministry to engage with the Ontario Medical Association (OMA) through the negotiations and consultation processes of the Ontario Medical Association Representation Rights and Joint Negotiation and Dispute Resolution Agreement (OMA Representation Rights Agreement).

4.2.2 The Ministry Cannot Fully Justify Its Adoption of Patient-Enrolment Models as Compared to the Fee-for-Service Model

The Ministry Has Not Defined “Quality of Care”

One of the Ministry’s goals is to increase “quality of care” for patients of family physicians—but it has not clearly defined that term for patient-enrolment models, and it has set no targets to measure quality. The Ministry acknowledged that evaluations of quality of care in primary care are lacking but has made only limited progress in addressing this concern.

In 2014, Health Quality Ontario released a report introducing a Primary Care Performance Measurement Framework for Ontario. The report noted that Ontario does not have a co-ordinated and comprehensive approach to collect, analyze and report on the performance of the primary care system, and that almost no information on performance has been available to individual primary care practices other than data they collect and analyze themselves. However, many, if not most, practices lack the capacity to generate their own performance data. In the absence of such information, including time trends and peer comparisons, primary care providers find it hard to identify areas of possible improvement.

Close to 85% of the physicians who responded to our survey on billing, compensation and the overall health system agreed that at least 20% of physicians’ income should be based on quality of services. Consensus appears to be lacking on the meaning of this requirement, however. Some physicians indicated that, for example, the time they spend on educating patients about their health conditions, following up on patients and counselling them reflects the quality of services they provide. In contrast, a large number of physicians thought that thorough study and research are required to establish appropriate quality indicators. Some suggested that quality indicators should be specific not only to the specialty but also to the patients’ characteristics, and should be predictable, controllable, enforceable and dependent on the availability of accurate data.

The Ministry’s Cost-Effectiveness Evaluation of Patient-Enrolment Models Was Inconclusive

In May 2014, the Ministry completed an evaluation of the costs and benefits of Family Health Organizations and Family Health Groups, and assessed whether the incremental costs of these models are justified when compared to the traditional fee-for-service model. The evaluation concluded that while the additional costs associated with Family Health Groups and Family Health Organizations have resulted in improvements related to achieving the goals of primary health care reform, it is difficult to determine the degree to which the additional costs are justified when measured against the benefits. Therefore, the evaluation was unable to provide a direct answer to the question of whether or not the incremental cost increase is fully justified.

In 2015, the Ministry developed a performance report that consolidated a number of statistics and performance metrics for each patient-enrolment model. The report was developed only for the 2014/15 fiscal year and did not include any benchmarks or standards against which reported metrics could be measured. For example, the report noted that the percentage of eligible individuals who received an influenza vaccination ranged from as low as 0% in certain family practices to as high as 73% in others. However, there was no indication as to what an appropriate percentage would be. Benchmarking against performance standards (or against the achievements of high-performing systems) helps establish performance targets and quantify the potential for improvement. The Ministry indicated that the performance report is the closest it has come to a comprehensive assessment of the different models’ performance.

We noted that the only area in primary care where the Ministry has established a formal mechanism for monitoring performance and assessing quality is for its inter-professional primary care organizations, such as Family Health Teams. Since the 2013/14 fiscal year, Health Quality Ontario has required these organizations to submit a Quality

Improvement Plan annually. This plan details an organization's progress on a set of provincial priority indicators. For each indicator, organizations are required to set targets and report their performance against these targets. For example, for colorectal, breast and cervical cancer screening, organizations are required to report on the percentage of patients who are up to date on their screening. This is in contrast to the Ministry's internal performance report mentioned earlier, which only reported on the percentage of patients who had a screening.

We noted from the results of the 2015/16 Quality Improvement Plan that the majority of Family Health Teams did not meet their indicator targets. For each of the 11 indicators reported on, targets were met or exceeded only between 18% and 52% of the time. However, because only about 3,000 physicians joined inter-professional teams, and only approximately 25% of Ontarians receive primary care through these inter-professional teams, these Quality Improvement Plans do not capture performance levels for all physicians in Ontario.

RECOMMENDATION 2

To help ensure that patients receive better-quality care that is cost effective and that patient-enrolment models for family physicians meet the goals and objectives of the Ministry of Health and Long-Term Care (Ministry), the Ministry should:

- clearly define indicators to measure “quality of care” for enrolled patients;
- establish targets that the patient-enrolment models should achieve within a given period of time; and
- collect and publish relevant and reliable data to monitor and assess performance against targets on a regular basis.

MINISTRY RESPONSE

The Ministry supports this recommendation, and, in collaboration with Health Quality Ontario, has made significant progress in

defining “quality of care” in recent years, most significantly through the development of Health Quality Ontario's Primary Care Performance Measurement Framework. The Ministry will work to build on this progress by finalizing priority indicators and establishing targets in support of greater transparency, measurement and oversight. This work is already underway, as improved measurement and monitoring of performance results are a key component of the Ministry's Patients First strategy.

The recommendation to publish relevant data is also highly consistent with the 2016 Mandate Letter from the Premier to the Minister of Health directing the Ministry to “[implement] a publicly available performance report to track and report on primary care access.” The Ministry will work to implement public reporting measures, consistent with the mandate and this recommendation, to support the monitoring and assessment of primary-care performance across the province.

4.2.3 The Higher Number of Family Physicians Has Not Shortened Wait Times

Between 2006/07 and 2015/16, the number of family physicians in Ontario, rose by 31%, from about 10,740 to about 14,100. Over the same period, the number of Ontarians who have a family physician rose by 43%, from roughly 7.4 million to 10.6 million. This increase was one of the purposes behind Ontario's move to patient-enrolment models (see **Section 2.2.2**). However, it has not translated into increased access to care as measured by wait times, 57% of Ontarians had to wait two days or more to see their family physician. This proportion is worse than the 51% reported in 2006/07, the first year when the Ministry began to collect the data. See **Figure 11** for the trend.

We noted that the Ministry does not have an administrative data system that allows it to collect complete, accurate and timely data relating to patients' same-day or next-day access. Therefore,

Figure 11: Percentage of Ontarians Who Waited Two Days or More to See Their Family Physician, Number of Family Physicians, and Patients Enrolled with a Family Physician, 2006/07 – 2015/16

Source of data: Ministry of Health and Long-Term Care and Institute for Clinical Evaluative Sciences

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
% of Ontarians who waited two days or more to see their family physician ¹	51	54	53	52	Not collected ²	Not collected ²	57 ³	55	56	57
# of family physicians ⁴	10,740	10,870	11,000	11,400	11,520	11,850	12,250	12,660	13,120	14,100
# of patients who are enrolled with a family physician (million)	7.4	8.2	8.8	9.2	9.5	9.8	10.0	10.2	10.4	10.6

1. The data was self-reported and is based on the results of Ministry's survey of Ontarians.

2. The Ministry did not collect survey data in fiscal years 2010/11 and 2011/12.

3. The Ministry's survey data covered only the six-month period from October 2012 to March 2013.

4. This is a headcount of general practitioners; data between 2006/07 and 2014/15 was obtained from the Institute for Clinical Evaluative Sciences, and 2015/16 data was obtained from the Ministry. The numbers are rounded to the nearest tenth.

the Ministry has since 2006/07 collected survey data on a quarterly basis to obtain an understanding of patient access.

Timely Access to Care and Access to After-Hours Care Lacking in Ontario

In 2014, the Commonwealth Fund conducted an International Health Policy Survey of Older Adults. (The Commonwealth Fund is a private U.S. foundation that conducts surveys on patients and providers in 11 developed countries.) This survey revealed that only about 44% of Ontarians aged 55 or older saw a physician in two days or less. This was on par with the rate in British Columbia and among the best in Canada, but significantly worse than the average of the 11 developed countries, 62%. This 2014 survey also found that 47% of the same group of patients in Ontario said it was very difficult or somewhat difficult to get medical care after hours. Again, this was on par with British Columbia and among the best in Canada, but significantly worse than the average, 29%, of the 11 developed countries.

4.2.4 Definition of “Regular Hours” Lacking and No Oversight to Ensure Family Physicians Meet After-Hours Requirements

The base capitation payments have been set on the assumption that patient-enrolment physicians will keep regular office hours of sufficient length for their patients to see them for non-urgent care and not have to visit emergency departments. The Family Health Organization contract states that “except for Recognized Holidays, the physicians shall ensure that a sufficient number of physicians are available to provide the services during reasonable and regular office hours from Monday through Friday sufficient and convenient to serve Enrolled Patients.” The terms “reasonable and regular” and “sufficient and convenient” are not defined in the contract, however.

Our review of Ministry data noted that for the 2014/15 fiscal year, each physician in a Family

Health Organization group worked an average of 3.4 days per week, and each Family Health Group physician worked an average of four days per week.

Patient-enrolment model contracts also do not stipulate the minimum number of services a physician or a group of physicians must perform over a given period of time. There is no mention of vacation times in the Family Health Organization and Family Health Group contracts. Physicians in a group will decide among themselves when to take vacation.

Many patient-enrolment family physicians do not work the number of weeknight or weekend hours required. However, the Ministry takes no action in such cases. While physicians in Family Health Organizations and Family Health Groups are required to provide a specified amount of after-hours services for their patients (defined as after 5:00 p.m. on weekdays and all day on weekends), we noted the following for the 2014/15 fiscal year:

- 60% of Family Health Organizations did not meet their after-hours requirements; and
- 36% of Family Health Groups did not meet their after-hours requirements.

Physicians are required to provide a minimum of a three-hour block of after-hours time for a specified number of days a week, depending on the number of physicians working in the group (for example, for a Family Health Organization with three physicians, the contract requires them to provide services for a minimum of a three-hour block on at least three days a week). Patient-enrolment contracts have no financial penalties for not meeting after-hours requirements, even though the result could be patients visiting emergency departments or walk-in clinics, leading to duplication on taxpayer money for services already paid for and covered under the base capitation payments. Ministry survey data for the period October 2014 to September 2015 showed that approximately 52% of Ontarians found it difficult to obtain medical care in the evening, on a weekend or on a public holiday without having to go to the emergency department. The same survey data showed that approximately 45% of Ontarians said that their family physician did not offer an after-hours clinic.

RECOMMENDATION 3

To ensure patients are able to access their family physicians in a timely manner when needed, and also to reduce the strain on emergency departments in hospitals, the Ministry of Health and Long-term Care should:

- clearly define the minimum number of regular hours (including evening and weekend requirements) in every patient-enrolment contract;
- regularly monitor and determine whether physicians participating in patient-enrolment models are meeting all their regular and after-hours requirements; and
- implement consequences of not meeting contract requirements, such as the imposition of an administrative penalty/fine.

MINISTRY RESPONSE

The Ministry supports this recommendation and will conduct a policy and contract review to evaluate whether the current enrolment-related provisions in the patient enrolment contracts contribute to improved access to primary care services for enrolled patients.

The Ministry will monitor to determine whether physicians participating in enrolment models are meeting all the regular and after-hours requirements, and will implement a program to make this determination.

Enabling these recommendations would require contract amendments. Contract amendments, including minimum number of regular hours and consequences for not meeting contract requirements, will require the Ministry to engage with the OMA through the negotiations and consultation processes of the OMA Representation Rights Agreement.

4.2.5 The Ministry Does Not Know Why Patients of Patient-Enrolment Physicians Sought Care Elsewhere

It was the Ministry's intention that by having patients sign an enrolment form when they enrolled with a family physician, they would seek all their primary care from that physician. However, the Ministry's billing system indicated that 40% of enrolled patients went to walk-in clinics or other family physicians outside the group with which they were enrolled in 2015. The same percentage was reported in 2013. The Ministry does not have complete information, such as which physicians are operating walk-in practices, which would allow it to study this trend further.

Use of Walk-In Clinics for Care That Could Be Provided by Family Physicians

Walk-in clinics provide quick access for patients who require immediate care. Best practices require that patients who have chronic health conditions should visit the same primary care physician for continuity of care. However, an estimated 27% of enrolled patients have chronic health conditions and regularly seek primary care outside the physician group with which they are enrolled. (The 27% estimate is based on the number of patients who seek care several times each year, and is a significant portion of the 40% of all enrolled patients who seek outside care.) The Ministry does not know why this group continues seeking outside care, mainly because it has no way to identify which physicians operate a walk-in clinic or family physician practice, or both, which would let it do further analysis.

We noted that the following reasons could contribute to outside use:

- convenience for patients—for example, many walk-in clinics operate in the Greater Toronto Area, and these clinics may be convenient for people who work in the area but whose family physician could be miles away; and
- unavailability of family physician—for example, because there were too many

patients waiting during opening hours, leading to long wait times; the practice was not open during certain regular hours, after hours or on statutory holidays; or the physician was on holiday.

Lack of Integration Between Walk-In Clinics and Family Physician Practices

The Ministry's survey data for the period October 2014 to September 2015 showed that approximately 30% of Ontarians had visited a walk-in clinic in the last 12 months. However, the Ministry has not required physicians to share patients' records between walk-in clinics and family physician practices. As a result, the continuity of care is hampered by the lack of integration between walk-in clinics and family physician practices and there may be duplication of services such as diagnostic testing. Although the Ministry notified family physicians on a monthly basis of which of their enrolment patients had sought outside care, the Ministry does not know how often the family physicians would follow up with their enrolled patients to understand why they seek outside care, and whether the family physicians have all the information they need to continue to provide comprehensive care to their enrolled patients.

RECOMMENDATION 4

To ensure that patients are able to receive continuity of primary care as stated in one of the Ministry of Health and Long-Term Care's (Ministry's) objectives, the Ministry should explore different options, such as requiring that patient records be shared between physicians, in order to better co-ordinate care for patients who continuously seek care from more than one primary care physician over time and implement change with the ultimate objective of putting the patient first.

MINISTRY RESPONSE

The Ministry welcomes this recommendation as it supports continuity of care for all patients. The Ministry will review options for sharing of patient health data in an effort to improve coordination of care for patients receiving care by more than one physician. This review would occur within the context of the Ministry's recently launched Patients First strategy. A key priority of Patients First is to implement local reforms to support greater information-sharing within local communities, and one aspect of this would be information-sharing amongst primary care practices, including from walk-in clinics to a patient's regular physician.

High Use of Emergency Department Services for Non-Urgent Care That Could be Provided by Family Physicians

During 2014/15, about 243,000 visits were made to emergency departments for conditions that could have been treated in a primary care setting. The Ministry estimated these visits cost \$62 million, of which \$33 million was incurred by patients enrolled in Family Health Organizations. This \$33 million is duplication of taxpayer money for services already paid for and covered under the contracts with Family Health Organization physicians. The Ministry does not recover these duplicate costs from the compensation paid to these patients' family physicians, however, because it does not want to deter patients from going to emergency departments in case their health conditions actually require emergency care.

However, we noted that the Ministry's survey for the period September 2014 to October 2015 reported that 42% of Ontarians (the same percentage as in 2013) indicated that the last time they went to an emergency department was for a condition that could be treated by their primary care physician if he or she had been available. The same survey also found that 26% said they had gone to

an emergency department because their primary care physician was not available. We also noted that, of the approximately 243,000 emergency department visits made during 2014/15 that could have been treated by family physicians, about 60% were made after hours (after 5:00 p.m. and on weekends), and about 40% were made during regular hours (weekdays between 8:00 a.m. and 5:00 p.m.).

Access to after-hours care is also a problem elsewhere in Canada, and is significantly below the international average of 10 developed and industrialized countries, based on the Commonwealth Fund International Health Policy Survey of 2015. In Canada, 48% of physicians reported that they have an arrangement in their practice where patients can see a physician or nurse when the practice is closed or after hours without going to the hospital emergency department. Canada's average was far below the 75% of physicians who reported the same in the 10 developed countries. We noted that the better-performing jurisdictions have various after-hours arrangements in place:

- In England, general practitioners can choose whether to provide 24-hour care for their patients or to transfer responsibility for out-of-hours services to the National Health Service or delegate out-of-hours services to a general practitioner co-operative.
- In New Zealand, after-hours services are organized at the regional level and have different hours of operation depending on the specific network's contractual requirements.

In Denmark, a country that was not included in the survey, after-hours service can be first accessed remotely for a prescription or referral to a hospital or treatment centre to see a provider. In 1994, Denmark restructured the delivery and organizing structure of the after-hours service and transitioned responsibility to counties. At the time of our audit, the Ministry has considered these best practices adopted from other jurisdictions.

We discuss some of the financial consequences of outside use by enrolled patients in **Section 4.4.2**.

RECOMMENDATION 5

To minimize the number of patient visits to emergency departments for non-urgent care that could be provided in a primary care setting, the Ministry of Health and Long-term Care should:

- evaluate whether the existing after-hours services offered by the contracted physicians are sufficient for their enrolled patients to obtain non-urgent care;
- better educate patients on the most appropriate place for non-urgent care when their family physicians are not available; and
- consider best practices from other jurisdictions, such as for ensuring that after-hours care is easily accessible by patients within their local communities.

MINISTRY RESPONSE

The Ministry welcomes this recommendation and supports that emergency department visits for non-urgent care should be provided in a primary health-care setting. However, in many rural areas of the province, primary health-care physicians are often responsible for much of the work being done in emergency departments and in other parts of hospitals. The Ministry agrees to:

- evaluate whether existing after-hours services offered by the enrolling physician are sufficient for enrolled patients to obtain non-urgent care;
- review existing communication strategy and investigate additional means of educating patients on the most appropriate place for non-urgent care; and
- conduct a review of best practices from other jurisdictions around access to care after regular business hours.

Enabling these recommendations would require contract amendments and will require the Ministry to engage with the OMA through the negotiations and consultation processes of the OMA Representation Rights Agreement.

4.3 Physician Payments Vary Widely

4.3.1 High Disparity of Gross Payment per Physician within Specialties

We noted that, even within the same specialty, there were large variances between the median gross billing paid and the gross billing paid at the 90th percentile. (The median is a useful average for this comparison—half are paid more than the median and half are paid less—and the 90th percentile is a good measure of the high extreme.) **Figure 12** lists the five specialties with the largest differences between their median and 90th percentile gross payments. The differences range from approximately \$460,400 to \$713,000.

When looking at physician compensation, it is important to note that these payments do not reflect physicians' net incomes, but rather their gross billings. This observation is supported by many of the physicians who responded to our survey, who indicated that comparing gross payments alone is misleading because, for example, overhead costs vary between regions. However, the Ministry does not know how much each physician has to pay for out-of-pocket costs such as rent, office expenses, administrative staff, supplies and equipment, so it does not have reliable information on physicians' net incomes. According to a 2012 article in the journal *Healthcare Policy*, physicians self-reported their average overhead as being about 28% of their gross clinical payment; it also suggested that overhead could be as high as 42.5% for physicians practising in ophthalmology.

In addition to lacking complete information on physicians' profit margin, the Ministry also lacks data on whether physicians work part-time or full-time, the size and scale of their practices, and individual physicians' hospital versus community practice. As a result, the Ministry cannot assess whether the differences in payment within specialties are reasonable.

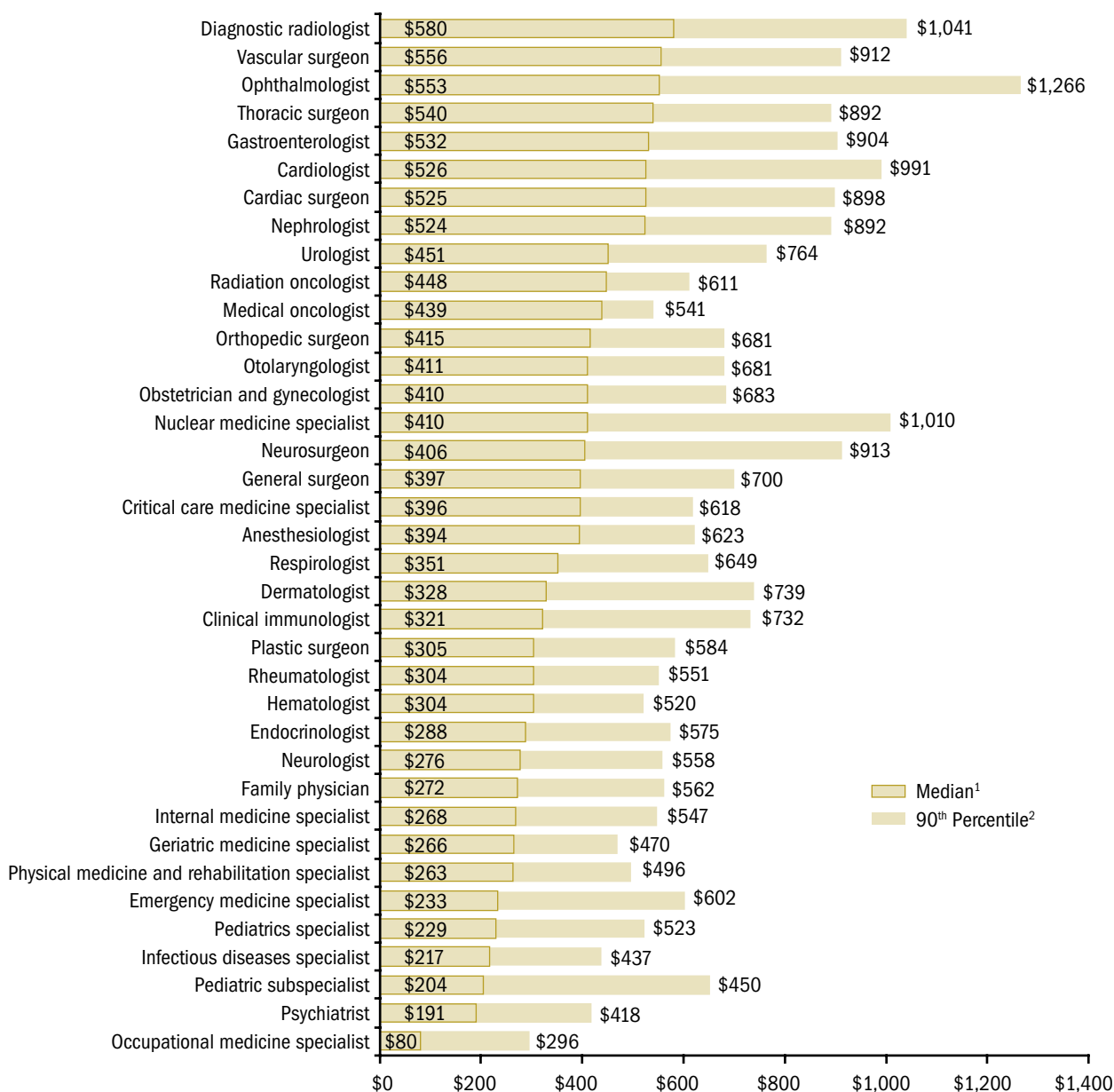
Figure 12: Specialties with the Largest Differences between Their Median and 90th Percentile Gross Payments, 2014/15

Source of data: Institute for Clinical Evaluative Sciences

Specialty	Median (\$)	90 th Percentile (\$)*	Difference (\$)	Difference (%)
Ophthalmologist	552,600	1,265,600	713,000	129
Nuclear medicine specialist	409,600	1,009,500	599,900	146
Neurosurgeon	405,700	912,700	507,000	125
Cardiologist	526,400	991,200	464,800	88
Radiologist	580,200	1,040,600	460,500	79

* The 90th percentile represents the higher end of the range for each specialty.**Figure 13: Median and 90th Percentile Payments to Physicians from OHIP by Specialty, 2014/15 (\$ 000)**

Source of data: Institute for Clinical Evaluative Sciences



1. Median payments are calculated using total headcount of Ontario physicians. These amounts are approximately \$40,000 more per specialty if both averages and full-time equivalent are used instead of the median and headcount.

2. The 90th percentile represents the higher end of the range for each specialty.

4.3.2 High Disparity of Gross Payment per Physician between Specialties

Average payments to physicians also differ significantly depending on medical specialty. **Figure 13** breaks down payments to physicians by specialty. We compared the median gross payment between specialties, and noted that the fee-for-service model in Ontario favours procedural specialists (those who perform procedures such as diagnostic testing or surgery) who generate a high volume of services. For example, in 2014/15:

- Diagnostic radiologists, the highest earning group in median gross billings, performed on average 21,750 services, but on average were paid \$29 per service.
- Vascular surgeons, the second-highest earning group in median gross billings, performed on average 12,230 services and were paid \$43 per service.
- Ophthalmologists, the third-highest earning group in median gross billings, performed on average 12,040 services, but on average were paid \$53 per service.

In contrast to the above examples, in 2014/15:

- Physicians practising internal medicine performed on average only 7,580 services and were paid \$40 per service.
- Pediatricians performed on average 6,810 services and were paid \$31 per service.
- Geriatricians performed on average 2,400 services but were paid \$74 per service.

This large difference in gross billings between physicians is primarily due to the differences in the nature of their work and how they are paid. Specifically, medical non-procedural specialists devote most of their time to patient visits and consultations. In contrast, procedural specialists tend to do procedures such as surgeries and diagnostic testing, which in a fee-for-service system allows them to bill for multiple services. It is the combination of a high volume of services and a relatively higher average fee paid per service that is responsible for the disparity between the specialties with the highest

gross billing and the other specialties. The exception is the diagnostic radiologists, whose average fees are relatively low but who are able to provide a very high volume of services.

Not all physicians think that these differences in fee-for-service billing rates are justified. Some physicians who responded to our survey commented that non-procedural specialists, such as pediatricians and psychiatrists, have been underpaid compared to procedural specialists such as ophthalmologists, because the former spend significantly more time with patients and their family members.

RECOMMENDATION 6

To get a better understanding of the significant variations in physician compensation within and between specialties, the Ministry of Health and Long-Term Care should obtain accurate information on physicians' practices, including their operating cost and profit margin in providing OHIP services.

MINISTRY RESPONSE

The Ministry welcomes this recommendation and will evaluate the feasibility of obtaining this information.

4.4 The Implementation of Patient-Enrolment Models Has Been Flawed

4.4.1 Physicians' Opting for Patient-Enrolment Models Not Necessarily Patient-Centred

The percentage of Ontario family physicians who opted to join patient-enrolment models has increased significantly—from 2% (202) in 2002 to about 75% (8,803) in 2015. Since the reform of the primary care system, physicians were given a choice of whether or not to enter into a model and also the type of model to enter into. However, although the opting-in process allowed physicians flexibility in

determining how they deliver care to their patients, the choice was physician-driven, not patient-driven or based on local needs.

The Ministry offered physicians a revenue analysis showing what their change in revenue would be if they switched from their current model to a new model:

- When Family Health Groups were introduced in 2003, the Ministry offered all physicians who were working in a strictly fee-for-service model a revenue analysis that showed what the estimated change in their annual revenue would be if they switched to a Family Health Group model.
- Similarly, when Family Health Organizations were introduced in 2006, the Ministry offered a similar revenue analysis to all physicians.

We noted that there was a significant switch from the Family Health Groups to Family Health Organizations primarily due to higher projected compensation at the time: the number of Family Health Organization physicians increased from 308 in 2006/07 to 5,057 in 2015/16, while the number of Family Health Group physicians fell from a high of 4,337 in 2007/08 to 2,618 in 2015/16.

Also, we noted the following:

- A 2015 research paper (published in Health Economics journal) found that physicians selected which payment model to enter into based on their existing practice characteristics. For example, physicians with more complex-needs patients were less likely to switch to enrolment-based models such as Family Health Organizations, where higher levels of effort were not financially rewarded.
- A 2012 report by the Institute for Clinical Evaluative Sciences found that patients in enrolment-based models with high capitation payments such as Family Health Organizations were from higher-income neighbourhoods and had a lower illness profile than patients in low-capitation-payment models such as Family Health Groups.

4.4.2 Implementation of the Access Bonus Resulted in Duplicate Payments

The Ministry spent between \$67 and \$100 million per year between 2010/11 and 2014/15 on a physician incentive called the “access bonus,” which is supposed to help ensure continuity of primary care. The bonus is meant to encourage family physicians in certain patient-enrolment models, including Family Health Organizations, to be available to their enrolled patients so those patients do not seek primary care services from outside sources.

The implementation of the access bonus is complex, and works as follows:

- Family physicians participating in patient-enrolment models receive a bonus that can amount to approximately 20% of the base capitation payment.
- A portion of a physician’s access bonus is held back each time his or her patients seek primary care services from outside sources such as walk-in clinics, but not when patients seek primary care from emergency departments. The amount held back from the bonus is equal to the fee-for-service payments made by the Ministry to the outside physician who treated the patient.
- The amount held back can be equal to the entire bonus.
- If patients do not seek primary care services from outside sources, then no part of the base capitation payment is held back.

Patients in Ontario are not restricted from seeking health-care services from walk-in clinics or other settings, regardless of whether they are enrolled with a family physician or not. In 2014/15, almost all physicians had some enrolled patients who visited family physicians outside their care, and as a result the maximum amount of access bonus available, \$207.3 million, was reduced by \$109 million. The remaining \$98.3 million was paid out to physicians as the incentive.

In some cases, when patients visit physicians other than the one they are enrolled with, the

Ministry pays twice for services already covered under enrolment-based payments—once through the capitation payments to the family physician practising under a patient-enrolment model, and again through the fee-for-service payment to the other physician (for example, a physician practising at a walk-in clinic). The reason for this duplication is that the deduction penalty is capped at a maximum, and after that maximum has been reached, the Ministry essentially pays a second time for the same service. We noted that for the 2014/15 fiscal year alone, the Ministry paid an additional \$15.7 million to cover services provided to patients who should have seen their own family physicians but went elsewhere. The result was duplicate payments of \$76.3 million cumulatively over the five years leading up to fiscal 2014/15 (see **Figure 14**). The Ministry does not recover these duplicate payments. We identified the same issue with duplicate payments in our *2011 Annual Report* section, **Funding Alternatives for Family Physicians**.

In 2013, the Ministry established a working group to conduct a policy review of the access bonus incentive. The group cited geography and convenience as key determinants in whether

enrolled patients seek outside care. It noted that during 2014/15, the patient-enrolment models with the highest rates of outside care were primarily concentrated in the Greater Toronto Area. Patients in this area have more primary care options, such as walk-in clinics, than patients in rural areas. However, the working group could not adequately measure the impact of walk-in clinics on physicians' access bonus, since there is no way to distinguish a walk-in clinic in Ministry data (walk-in clinics are not required to submit claims using a specific group identifier).

We noted that the structure of the bonus payments system may favour physicians practising in smaller urban and rural areas. Visits to emergency departments for conditions that could be treated in a primary care setting do not affect a physician's access bonus. We found that rural and smaller urban areas had a significantly higher number of emergency department visits than large urban areas. For example, in 2014/15, a large urban region with a population of approximately 1.4 million had approximately 6,000 emergency department visits, while a smaller urban/more rural region with a population of approximately 560,000 had approximately 20,000 of these visits. This could in part be due to the availability of fewer primary care options, such as walk-in clinics, in these regions. The fact that these emergency department visits do not affect a physician's access bonus could contribute to the higher access bonuses that physicians in smaller urban and rural areas earn than physicians in large urban areas.

The Ministry's access bonus working group made a number of recommendations in May 2014; however, after the breakdown in the Ministry's negotiations with the Ontario Medical Association, none of the report's recommendations have been implemented. Some key recommendations from the working group are:

- targeted physician education through an advisory team of physicians and administrators that the province could set up to help the groups with significant access bonus problems

Figure 14: Duplicated Payments for Services Covered under Base Capitation Fees, 2010/11–2014/15

Source of data: Ministry of Health and Long-Term Care

Fiscal Year	Duplicate Payment (\$ million)
2010/11	13.8
2011/12	18.6
2012/13	15.4
2013/14	12.8
2014/15	15.7
Total	76.3

Note: Physicians who are under high base capitation fee models, such as Family Health Organizations, can earn a bonus amounting to 20% of their base capitation fee. The Ministry deducts a portion of the bonus from the family physicians each time their enrolled patients seek outside care (such as walk-ins), but it caps the deductions so that the remaining 80% of the base capitation fee is not affected. Because of this cap on deductions, in some cases the Ministry pays twice for the services already covered under the base capitation fee—once through base capitation payments to family physicians practising under patient-enrolment models, and again through fee-for-service payments to other physicians who actually treated the patients (e.g., physicians practising at walk-in clinics).

identify the issues and recommend solutions based on the individual circumstances;

- improved reporting to physicians to help them better understand outside use by their patients (for example, the list of top outside users) and better identify the options available to address this issue;
- review of the services listed under the base capitation basket in certain patient-enrolment contracts;
- improved patient education by making patients fully aware of the commitment they make to see their family physicians for the basket of services when they sign the Enrolment Form; and
- collection by the Ministry of comprehensive, province-wide data on daytime access to services, from both the physician group and patient perspectives.

RECOMMENDATION 7

To ensure that the access bonus paid to encourage family physicians in patient-enrolment models has its intended effect, and that the bonus does not result in duplicate payments for some medical services, the Ministry of Health and Long-Term Care should:

- implement the recommendations from its policy review on the access bonus to educate targeted physicians, improve reporting to physicians to help them better understand their patients' use of outside services, and improve patient education by making patients fully aware of the commitment they agree to when they enroll with their family physicians; and
- redesign the bonus so that the Ministry does not pay for duplicated services.

MINISTRY RESPONSE

The Ministry supports this recommendation and will undertake a review of the information received by the patient at the time of enrolment

and the reporting received by the physician regarding enrolled patients who have been provided services outside the enrolling group. The focus of the review will be:

- education on the meaning of “enrolment” and what the patient is agreeing to when signing a roster form; and
- additional reporting to physicians on patients who are receiving services outside the group.

In addition, the Ministry will conduct a review regarding the redesign of the access bonus to include an examination of the number of groups that have patients receiving services outside the enrolling group in excess of the access bonus and expenditures by the Ministry. The review will include a determination whether any changes to the “hold back” are necessary.

Enabling these recommendations would require contract amendments. Any change to the access bonus will require the Ministry to engage with the OMA through the negotiations and consultation processes of the OMA Representation Rights Agreement.

4.4.3 Some Payments to Family Physicians under Patient-Enrolment Models Could Have Been Saved

As Physician Services Agreements have been renegotiated over the last 15 years, various special payments and programs have been added to patient-enrolment models. These payments have complicated overall fee structures, and it is no longer obvious what some of them are for, what needs to be done to qualify for them, or whether they are still necessary. We noted the following examples:

- In 2014/15, \$364 million was paid to all family physicians who opted for patient-enrolment models, under an agreement by which each family physician practising in a patient-enrolment model receives approximately \$3 per month, on top of the base capitation

payments, for each enrolled patient. This payment was negotiated in the 2004 Physician Services Agreement. However, it is not clear how this payment impacts quality of care. The Ministry proposed reducing the dollar amount of the payment in its negotiations with the OMA on the 2014 Physician Services Agreement, but at the time of our audit the parties had not reached an agreement and no progress had been made. For the five years up to and including 2014/15, the payment amounted to approximately \$1.7 billion.

- In 2002, the Ministry introduced a number of premiums that are one-time payments to offset costs associated with the building of a patient roster and to encourage physicians to enroll complex-needs patients who are without family physicians. The Ministry discontinued some of these premiums in June 2015 after a review found they were no longer required to incentivize physicians and that cutting them would save an estimated \$34.2 million in 2015/16 and \$41 million in 2016/17. Had the Ministry completed its review earlier, it could have found more savings by negotiating this change in the 2008 or 2012 Physician Services Agreement.
- The Ministry created the Diabetes Management Incentive Code in 2002 to encourage primary care physicians to provide optimal, comprehensive care for diabetic patients. The Ministry did not review the cost-effectiveness of this incentive until 2012, when an Institute for Clinical Evaluative Sciences study concluded that the code led to only minimal improvements in the quality of diabetes care and that the physicians claiming it had likely already been providing the highest quality of care to their diabetic patients before the incentive was introduced. The Ministry finally amended payment criteria for the code in September 2015, estimating that the changes would result in \$8 million in annual savings.

4.4.4 Base Capitation Payments May Not Be Serving Their Intended Purpose

Overpayments Made in Modification of Base Capitation Payments

Base capitation payments are meant to account for the cost of the primary care required by patients based simply on their age and sex. However, the Ministry realizes that age- and gender-based capitation payments do not adequately capture the variation in need for primary care services among patient populations, and that the current system does not account for the time and resources needed to care for patients with complex medical conditions. The Ministry has attempted to address this problem, although its most recent effort was not well implemented.

In January 2014, the Ministry paid \$40 million as an interim payment modifier to all patient-enrolment physicians who treated high-needs patients enrolled in their practices. Out of this \$40 million, \$17.4 million was paid to approximately 3,400 physicians who were in patient-enrolment models that are compensated on an enhanced fee-for-service basis—which indicates that these physicians were already being compensated for treating their high-needs patients. These 3,400 physicians therefore should not have received the payment. However, although the \$17.4 million in payments was not justified, the Ministry agreed to let the payments stand after its negotiations with the Ontario Medical Association in 2012. The Ministry informed us that it was planning to limit this payment modifier to only the physicians it was intended for, but the implementation has been put on hold since March 31, 2014, after the breakdown in Physician Services Agreement negotiations between the Ministry and the Ontario Medical Association.

Some Enrolled Patients Did Not Visit Their Family Physicians At All

The Ministry pays base capitation payments to Family Health Organizations on the assumption that these family physicians are actually providing med-

ical services for the patients they enrol. However, in 2014/15, 1.78 million (or 33%) of the 5.4 million patients enrolled with a Family Health Organization did not visit their family physicians at all, yet we estimated that these physicians still received a total of \$243 million just for having them enrolled. Males between the ages of 20 and 29 are the group most likely to not visit their family physician.

We reported the same concern in our *2011 Annual Report*. The Ministry responded at the time that because capitation payments are based on the average level of physician services used by persons of the same age and sex, it expected payments for patients who seldom or never visit their physician to be offset by the cost of treating those patients who require a high level of care. However, the Ministry could not provide any evidence for this offset and therefore could not substantiate whether its capitation payments are appropriate.

RECOMMENDATION 8

To better ensure that patient-enrolment models are cost-effective and that capitation payments, premiums and incentives achieve their intended purposes, the Ministry of Health and Long-Term Care should:

- pay capitation payments, premiums and incentives only where justified with evidence; and
- periodically review the number of patients who do not see the physician they are enrolled with, and assess whether continuing to pay physicians the full base capitation payments for these patients is reasonable.

MINISTRY RESPONSE

The Ministry welcomes this recommendation and agrees that payment of capitation, premiums and incentives should only take place when justified with evidence. The Ministry agrees to conduct a review of the capitation rate, including evaluation of the core services provided to patients by physicians who receive a

base capitation payment. Any change to the capitation rate, premiums and incentives will require the Ministry to engage with the OMA through the negotiations and consultation processes of the OMA Representation Rights Agreement.

However, the capitation rate is determined by looking at all patients, those who do receive services and those who do not. The capitation rate is based on the assumption that some patients will see their physician many more times than an average patient and others would not see their physician at all in any given year. The Ministry will review other jurisdictions' capitation rate methodology.

4.5 Oversight of Fee-for-Service Payments to Physicians Is Weak

4.5.1 The Ministry Does Not Investigate Many Anomalous Physician Billings

Fee-for-service billing is still widely used by specialists and many family physicians for providing services that are not covered under the base capitation payments within the patient-enrolment models. (As we noted in **Section 2.3**, in 2015/16, of the \$11.59 billion paid to all physicians in Ontario, about \$6.33 billion, or 55%, was paid mainly to specialists on a fee-for-service basis.) The fee-for-service claims paid to physicians are based on an honour system, as physicians are responsible for ensuring that the claims they submit comply with the Schedule of Benefits. In addition, the Ministry has established a Payment Accountability Unit to review physician claims to ensure that they are appropriate. This unit educates physicians on the claims-submission process and pursues recovery of any overpayments resulting from claims-submission errors.

The Ministry analyzes paid claims through post-payment reviews to determine if the physicians submitted their claims properly and in accordance with the Schedule of Benefits. There are two types of post-payment review: reactive and proactive reviews.

The Ministry Adequately Addressed Public Complaints through Reactive Reviews

Under reactive reviews, the Ministry reviews individual physicians as a result of a complaint from the public or another physician, or as a result of a treatment being disputed on the basis of random verification letters the Ministry sends some patients. **Figure 15** shows the number of reactive reviews since 2011/12 and their results. Most recently, in 2015/16, the Ministry was recovering about \$243,000 from 14 physicians.

The Ministry Identified Some Billing Anomalies through Proactive Reviews

Under proactive reviews, the Ministry identifies certain physicians as anomalous billers through statistical analysis of their billing and profile review. **Figure 16** shows the number of physicians flagged by the Ministry's proactive reviews between 2011 and 2015, and the results. Although the Ministry is able to identify anomalies and outliers, it explained that it did not investigate many cases because further investigation often requires significant time and effort. Since the beginning of 2013, it has not actively pursued recovery of overpayments; it was recovering approximately \$19,700 in 2014 and nothing in both 2013 and 2015. For further details, refer to **Section 4.5.3, The Ministry Lacks Effective Enforcement Mechanisms to Recover Inappropriate Payments from Physicians.**

We also noted that, at the time of our audit, the Ministry had identified over 500 physicians who billed over \$1 million each to OHIP in 2014/15, and had selected 12 of them for further analysis, based on available resources. The Ministry suspected that some of these billings might have been inappropriate: for instance, medically unnecessary services might have been performed or payment made for services that had not been rendered, or the standard of care might have been breached in other ways. For example:

- One ophthalmologist billed \$6.6 million during 2014/15. The majority of this physician's billings came from performing laser procedures. The physician performed the procedures on average seven times per patient over the year. This physician also billed about \$1.4 million to the province for diagnostic testing. Ordering unnecessary diagnostic tests by ophthalmologists is cited for caution by the Choosing Wisely national health campaign in the U.S. and Canada. Choosing Wisely encourages conversation between physicians and patients about unnecessary tests, treatments and procedures.
- One cardiologist billed \$2.5 million during 2014/15. This physician performed over 68,000 services over the year, more than six times the number of services rendered by the average cardiologist. A large amount of this physician's billings came from giving

Figure 15: Number and Outcomes of the Ministry's Reactive Reviews, 2011/12–2015/16

Source of data: Ministry of Health and Long-Term Care

Fiscal Year	# of Physicians Reviewed Based on Complaints Received	Upon Further Review, No Issues Were Noted ¹	Physician Was Either Educated on Correct Billing or Referred to Other Entities ²	# of Physicians from Whom Inappropriate Payments Were Recovered	Amount Being Recovered (\$)
2011/12	746	543	178	25	422,500
2012/13	699	470	202	27	758,700
2013/14	302	178	117	7	218,800
2014/15	178	94	79	5	258,400
2015/16	82	19	49	14	243,000

1. Many complaints were found to be unsubstantiated.

2. Other entities include other areas within the Ministry and the College of Physicians and Surgeons of Ontario.

Figure 16: Results of Ministry's Proactive Reviews, 2011-2015

Source of data: Ministry of Health and Long-Term Care

Calendar Year	# of Physicians Flagged for Anomalous Billings	# of Physicians from Whom Overpayments Were Recovered	Amount Being Recovered (\$)
2011	251	243	1,065,500
2012	356	184	1,837,000
2013	38	0	0
2014	221	1	19,700
2015	62	0	0

echocardiograms, Holter monitoring tests, stress tests and consultations. Echocardiograms and stress tests are widely accepted by the medical community to be at risk of being overutilized by cardiologists, as noted in the Choosing Wisely Canada campaign.

It is important to note that determining whether a service is medically necessary or not requires significant professional judgment.

The Ministry Does Not Investigate Many Other Anomalous Physician Billings

Our review of more recent data found at least 648 specialists whose billing trends were anomalous when compared to the expected range of days billed and services by specialty category for fiscal 2015/16. **Figure 17** identifies the number of specialists who were outside these ranges.

The standard or expected number of days billed annually and the expected number of annual services varies depending on the type of work the specialist is involved in. For example, a specialist who does diagnostic-type procedures, such as a diagnostic radiologist, typically bills between 183 and 235 days annually. The number of expected annual diagnostic services ranges between 5,366 and 10,266. The 648 specialists we identified, as indicated in **Figure 17**, billed a greater number of days than the upper limit of expected days. Of these 648 specialists, 406 also had more services than the upper limit of expected standard services.

We note that, in particular, nine specialists worked over 360 days, and six of them worked every single day of the year, 366 days (2016 was a leap year).

- One respirologist worked 361 days in 2015/16 and billed the province \$1.3 million, which is 4.9 times the upper expected limit for physicians in the same billing category, non-procedural specialists. This specialist provided close to 12,400 services that year, 3.9 times the upper range of expected services for physicians in his billing category.
- One cardiologist worked 354 days in 2015/16 and billed the province \$1.8 million, which is three times higher than the upper expected limit for physicians in the same billing category, procedural specialists. This specialist provided over 13,200 services that year, 2.4 times the upper range of expected services for physicians in the same billing category.
- One diagnostic radiologist worked 313 days in 2015/16 and billed the province \$1.7 million, which is 2.8 times the upper expected limit for physicians in the same billing category, diagnostic specialists. This specialist had over 57,400 diagnostic services that year, 5.6 times the upper range of expected services for physicians in the same billing category.

At the time of our audit, the Ministry had not started looking into the anomalous billings we identified.

The Ministry's Schedule of Benefits Could Encourage Strategic Billing

In addition, we also noted that these high gross billings are achievable primarily because the Schedule of Benefits tends to pay a high dollar amount for the time it takes to perform the procedures. This is consistent with our finding in **Section 4.3.2** that the highest-billing physicians can either bill extremely high volumes (for example, diagnostic radiologists) with a lower fee per service or moderately high volumes (for example, vascular surgeons and ophthalmologists) with a relatively higher fee per service.

Figure 17: Number of Specialists Outside the Upper Limit of Expected Days Billed and Services, by Specialty Category, 2015/16

Source of data: Ministry of Health and Long-Term Care

Specialty Category	# of Days Billed		# of Services	
	Expected Annual Range ¹	# of Specialists Exceeding Upper End of Range	Expected Annual Range ¹	# of Specialists Exceeding Upper End of Range
Diagnostic ²	183-235	58	5,366-10,226	45 of 58
Procedural ³	199-239	44	3,135-5,497	30 of 44
Non-procedural ⁴	148-190	221	1,720-3,176	154 of 221
Surgical ⁵	185-225	196	2,603-4,253	98 of 196
Time based ⁶	148-184	129	809-1,543	79 of 129
Total		648⁷		406 of 648

1. The expected range is calculated based on 0.25 of a standard deviation on either side of the calculated median, using actual physician billing for 2015/16.
2. Includes specialists such as pathologists and diagnostic radiologists.
3. Includes specialists such as nephrologists and cardiologists.
4. Includes specialists such as geriatricians and respirologists.
5. Includes specialists such as neurosurgeons, general surgeons and ophthalmologists.
6. Includes specialists such as psychiatrists and anesthesiologists.
7. The 648 specialists are part of the larger group of 1,129 specialists, who were first identified by filtering their billing data that shows they were outside of the expected annual range for any three of the following four indicators: number of days worked, number of patient visits, number of distinct patients treated and the amount billed.

The Schedule of Benefits could be providing some physicians with an incentive to schedule patient visits and perform medical services strategically in a way that maximizes their billing. (See also **Section 4.6**, where we discuss utilization of health-care services.)

RECOMMENDATION 9

To ensure that health-care dollars are spent only on procedures that are medically necessary, the Ministry of Health and Long-Term Care should work with the appropriate medical professionals to:

- establish evidence-based standards and guidelines for each specialty to ensure all procedures and/or tests performed are medically necessary for patients; and
- provide better education to patients on the common procedures that are not evidence-based.

MINISTRY RESPONSE

The Ministry supports this recommendation. The Ministry will look to convene medical experts to review medical diagnostics.

In addition, Health Quality Ontario (HQP) has recently launched a Quality Standards program. The goal of the Quality Standards program is to reduce existing variations in practice across the province and improve quality care delivery through the development of condition-specific standards that outline evidence-based best practices in relevant health-care settings. The quality standards serve as a resource for clinicians in determining the most appropriate care pathways throughout the care continuum, and include recommendations that are specific to diagnostic procedures and treatment modalities. Furthermore, the standards include a clear, concise guide to assist patients and caregivers in knowing what to expect in their care, to encourage dialogue between clinicians

and patients, and to ensure information is both consistent and accurate when it is shared both with patients and caregivers and within the inter-professional care team.

HQO also supports Choosing Wisely Canada (CWC), a program aimed at helping clinicians and patients engage in conversations about unnecessary tests, treatments and procedures. CWC has released over 180 lists of “things clinicians and patients should question” to support those conversations.

4.5.2 The Ministry Has Had No Inspector Function Since 2005

In 2005, the Ministry drastically changed the way it audits payments made to physicians. The change was in response to a report requested by the government in 2004 and prepared by a retired Justice of the Supreme Court of Canada, the Honourable Peter DeCarteret Cory (the Cory Report). Justice Cory reviewed the Ministry’s process for auditing physicians’ billings and made recommendations on how to change the system. At that time, the Ministry employed audit inspectors through the College of Physicians and Surgeons of Ontario, who could inspect physicians’ medical records on-site, interview physicians and make observations within their practices. Physicians viewed this inspection process as unfair.

On April 21, 2005, Justice Cory concluded in his report that the Ministry’s audit process had a debilitating and devastating effect on Ontario physicians and their families. The Cory Report included 118 recommendations on establishing a new medical audit process. The Ministry proposed in its Treasury Board submission that it would implement 60 of the 118 recommendations as stated, implement another 33 with modifications, and not implement the remaining 25. Of the 25 recommendations not implemented, 22 related to the inspector function—that is, giving inspectors power to inspect medical records on-site, interview physicians and make observations within a physician’s practice.

The Ministry’s current audit process uses medical advisers rather than inspectors. Advisers can only review medical records off-site, after they receive copies of medical records from the physicians.

As we explain in **Section 4.5.3**, not having an inspector function has limited the Ministry’s ability to recover inappropriate payments. We noted that both British Columbia and Alberta conduct on-site inspections as part of their physician billing audits when they deem them to be necessary.

In our survey of physicians, we received mixed results when we asked whether the Ministry has done enough to oversee and audit OHIP payments to physicians. While 33% of surveyed physicians agreed, 28% disagreed, with the remaining 39% saying they don’t know or have no opinion. Some physicians mentioned that more needs to be done to deter physicians from continuing to bill inappropriately. Some others suggested that the Ministry should do more to communicate what billings it has audited and should report on the results. A few others suggested that the Ministry should educate physicians, both new and experienced, in how to bill properly.

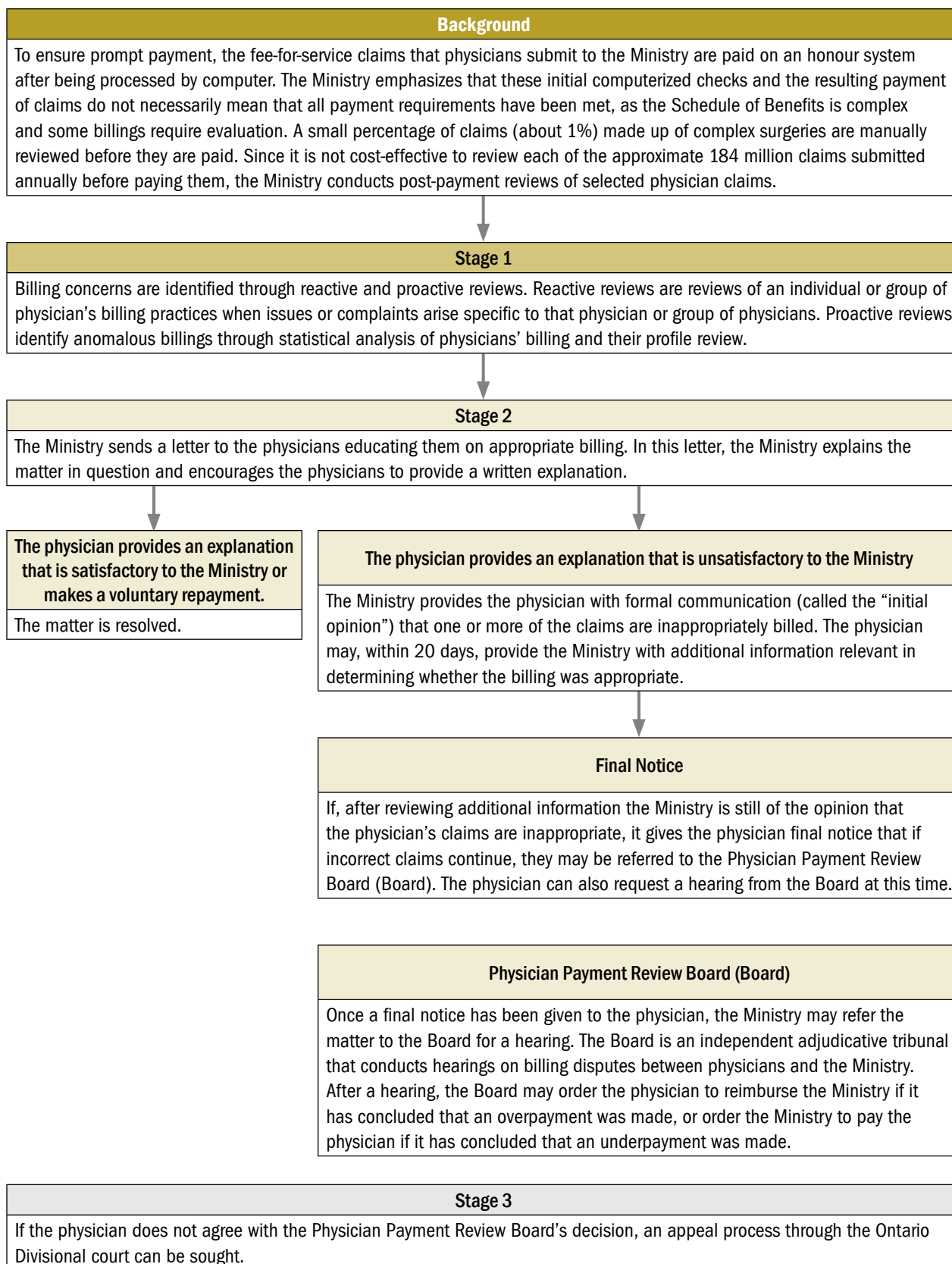
4.5.3 The Ministry Lacks Effective Enforcement Mechanisms to Recover Inappropriate Payments from Physicians

The Ministry’s current recovery process (detailed in **Figure 18**) on inappropriate physician billings is ineffective, lengthy and resource-intensive. Under this process, the onus is on the Ministry to prove that the physicians are in the wrong, not on the physicians to prove that they are right. The review and recovery process differs from the approach adopted by the Canada Revenue Agency, which requires taxpayers to prove that they are right.

Since the Ministry has changed how it audits payments made to physicians as a result of the Cory Report, it has focused more on educating physicians on how to bill appropriately, while it focuses too little on attempting to recover these overpayments. Unless a physician agrees to repay amounts volun-

Figure 18: Ministry of Health and Long-Term Care's Fee-for-Service Billing Review Process

Prepared by the Office of the Auditor General of Ontario



tarily, it is very difficult to recover inappropriate payments. This is because the legislative changes introduced after the Cory Report restrict the Ministry from ordering a physician to repay an overpayment or incorrectly submitted claim unless it has an order from the Physician Payment Review Board (Board). The Board was established after the Cory Report to conduct independent reviews of payment disputes between physicians and the Ministry, to make the process fairer and more transparent for physicians. We noted that both Alberta and British Columbia have the ability to order a physician to repay overpayments without having to obtain an order from a similar Board. However, the Ministry rarely refers cases to the Board. In fact, since the Board's inception in 2010, only five cases have proceeded to formal hearings. This has resulted in inappropriate payments made but not recovered by the Ministry, as we explain in the next section.

Inappropriate Payments Made Were Not Recovered

We found many instances when even though the Ministry had evidence to confirm certain billings were not legitimate, it did not make an effort to recover overpayments from the physicians. For example:

- Through a proactive review in 2014, the Ministry identified a specialist who was billing a fee code the specialist was not eligible for. The amount at risk of overpayment was about \$77,000 in 2010/11 and \$59,000 in 2011/12. Although the specialist provided an unacceptable explanation of the billing to the Ministry, the Ministry did not attempt to recover the overpayment. We identified that this specialist continues to bill inappropriately. From September 2014 (the date the Ministry became aware that billing was inappropriate) to May 2016 (the time of our audit), the specialist had billed this code more than 380 times, for a total of approximately \$121,700. After we brought this issue to the Ministry's atten-

tion, it indicated to us that it would follow up on this specialist.

- The Ministry identified, through the same proactive review, another specialist who was billing a fee code erroneously and identified \$19,700 worth of overpayments. The specialist voluntarily paid back this amount to the Ministry. However, we noted that the Ministry did not pursue recovery for other inappropriate amounts billed by this specialist and the group of 28 other specialists he works with. We estimated the overpayment to be approximately \$115,000 from April 1, 2012, to March 31, 2016.
- The Ministry acknowledged that other specialists are systematically billing one particular code inappropriately, and that it was a topic under consideration for future physician education. We identified 371 other specialists (beyond the previously mentioned group of 29) who were billing this code inappropriately and estimated that between April 1, 2012 and March 31, 2016, the overpayment amounted to approximately \$2.44 million. However, the Ministry had no plans to investigate further or to pursue recovery of overpayments. The Ministry informed us that it did not have resources to pursue the case further.

4.5.4 The Ministry No Longer Follows Up on All Physicians Who Had Inappropriate Billings

Since the Ministry focuses its efforts on educating physicians whose billings are inappropriate and instructing them to correct future billings, we expected that an on-going monitoring process would be in place to ensure that physicians with problematic billing corrected future billings. However, we found that the Ministry does not follow up on all of these physicians. Prior to December 2014, the Ministry would initiate a follow-up with physicians about six months after sending a letter instructing them to correct their billing. In

December 2014, the Ministry decided to stop the automatic follow-up process and replace it with a case-by-case process, because its review indicated that most physicians complied with the Ministry's instructions, and that further monitoring was not necessary for all cases. However, we found that the Ministry's analysis supporting this decision was flawed: in our analysis of 34 physicians who billed inappropriately, 21 had previous instances of inappropriate billing, and eight of these were for the same issues.

RECOMMENDATION 10

To strengthen the oversight of fee-for-service payments to physicians to ensure that taxpayer dollars are fully recovered in situations of inappropriate billings, the Ministry of Health and Long-Term Care should:

- evaluate the costs and benefits of amending the fee-for-service billing review process and re-establishing an inspector function to oversee physician billings;
- effectively monitor billings and ensure physicians correct their inappropriate billings on a timely basis;
- establish an effective mechanism to recover overpayments from physicians when inappropriate billings are confirmed; and
- streamline the existing review and education process for physician billing.

MINISTRY RESPONSE

The Ministry welcomes and agrees with recommendations regarding the need to strengthen the Ministry's ability to monitor payments to physicians and recover public funds against inappropriate billings. These recommendations support the Ministry's commitment to protecting the sustainability of Ontario's public health-care system.

The Ministry will:

- consider re-establishing an inspector function to oversee physician billings;

- review existing policy and make recommendations where appropriate;
 - review the physician payment accountability process;
 - increase the ability to effectively monitor and ensure timely physician compliance with correcting inappropriate billing; and
 - establish an effective mechanism to recover overpayments from physicians when inappropriate billing are confirmed through a streamlined review and education process.
- Implementation of these items would require additional resources, policy and/or legislative changes.

4.6 Ministry Having Challenges Managing Health-Care Services Billed Under the Fee-for-Service Model

Utilization is the measure of the population's use of the health-care services available to it. In a fee-for-service payment model, utilization is an important topic, because a higher volume of services means higher health-care costs. As of December 31, 2015, the Ministry's most recent available data indicates that utilization for fee-for-service claims has been growing at an annual rate of 3.3%, which is higher than its yearly expenditure growth rate of 1.25% (see **Figure 19**).

Because utilization is difficult to predict, it is hard to manage health-care spending, particularly under a fee-for-service model. Many factors drive changes in the rate of health-care use. For example, when technological advances make services easier and quicker for physicians to deliver, the volume of services increases. Also, patient attitudes and expectations have an impact on the volume of services physicians provide.

However, in a taxpayer-funded health-care system, the decision to provide a service should be based on whether it is medically necessary. To determine whether a test or procedure is medically necessary is a professional judgment. There are also

Figure 19: Percentage Change of Total Fee-for-Service Payments, Based on Volume, 2010/11–2015/16

Source of data: Ministry of Health and Long-Term Care

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16*
% increase	2.8	3.7	1.5	3.0	4.6	3.3

* Year to date as of December 31, 2015.

numerous evidence-based medical research studies that identify which treatments do not improve patients' outcomes. Choosing Wisely Canada publishes a list of over 175 tests and procedures that are not necessary under certain circumstances. For example:

- CT head scans should not be ordered in adults and children who have suffered minor head injuries;
- baseline electrocardiograms should not be ordered for patients without symptoms of heart problems undergoing low-risk non-cardiac surgery; and
- antibiotics should not be used in adults and children with uncomplicated sore throats.

One method of containing health-care costs in a fee-for-service model is through utilization management, that is, attempting to influence the volume of services provided by physicians—often, by increasing patient awareness.

In recent years, the Ministry has achieved some cost savings through utilization management and attempting to decrease medically unnecessary services. However, the actual savings realized from its initiatives were significantly less than expected. We noted the following examples:

- The Ministry targeted savings of \$26.7 million for 2013/14 by reducing the number of colorectal cancer follow-up screenings as a result of aligning to Cancer Care Ontario's guidelines for follow-up screening intervals. The actual savings were \$8.8 million—\$17.9 million below the original target.
- The Ministry targeted a savings of \$29 million for 2013/14 by eliminating annual physical health exams for healthy adult patients aged 18 to 64. The actual savings

were \$19.3 million—\$9.7 million below the original target. In January 2013, the Ministry replaced the annual physical health exam with an annual health visit, because evidence states that an annual physical examination is ineffective in finding hidden disease in healthy people. If a physician determines that a physical examination is necessary, as for patients with chronic illness, then a full physical examination is still insured by OHIP.

Because of the difficulties the Ministry faced in containing costs under the fee-for-service model, it implemented across-the-board cuts in 2015, even though this is not an ideal or sustainable way to contain costs, as described in the following section.

4.6.1 Without an Agreement, the Ministry Imposed a 4.45% Cut Cumulatively to Physician Compensation with No Evidence-Based Justification

The Ministry and the OMA have had no agreement in place since the last Physician Services Agreement expired on March 31, 2014. Because the parties could not reach an agreement but the Ministry saw the need to contain costs, it implemented across-the-board payment reductions to physicians twice during 2015. These reductions were in addition to the 0.5% agreed upon in April 2013, and added up to 4.45% for fee-for-service billings. For physicians who receive payments over \$1 million, the Ministry planned to reduce the payment by another 1% for the portion in excess of the first \$1 million. (See **Appendix 1** for a summary of fee changes since 2004.)

However, these across-the-board reductions were not evidence-based and, in some cases,

disproportionately impact lower-earning physicians as opposed to higher-income physicians.

The *Health Insurance Act* requires that the Ministry establish a committee to provide advice and recommendations on timely and appropriate revisions to the fee schedule and other payment programs. These are meant to reflect current medical practice and meet the needs of the health-care system. The committee has the additional intent to continue to bring fees into greater relative balance in accordance with innovation, access, integration and competitiveness. For example, when cataract surgery was performed 10 years ago, the procedure took about an hour and the total fee was \$516. Today, technological advancement has made this surgery much easier to perform and has decreased the time required to only about 15 minutes. As part of the committee's review, the total fee was reduced to \$442 in September 2011.

We noted that the Medical Services Payment Committee (Committee) was established as part of the 2004 Physician Services Agreement and operated until the last agreement expired in March 31, 2014. Without an agreement between the Ministry and the OMA, there is limited collaboration to adjust individual fees.

A majority, 83%, of the physicians who responded to our survey believed that the current negotiation process between the Ministry and the OMA is neither productive nor sustainable. Only a small portion, 7%, said the current process is productive and sustainable, while the remaining 10% don't know or had no opinion. Many physicians commented that the current negotiation process should be more balanced and not one-sided.

A large number of the physicians who responded to our survey emphasized that patients' demands are the driving force behind health-care costs. Many suggested that patient accountability is required to ensure that only necessary services or procedures are performed and costs are not duplicated.

RECOMMENDATION 11

To ensure that the fees on the Schedule of Benefits reflect current medical practice and the needs of the health-care system, the Ministry of Health and Long-Term Care should:

- re-establish the Medical Services Payment Committee to provide regular reviews of physicians' fees and evidence-based advice on fee revisions; and
- assess the impacts that technological advancements have had on treatment times for consideration in adjusting fee-for-service codes.

MINISTRY RESPONSE

The Ministry supports this recommendation and is prepared to undergo a review of physician fees and assess the impact that technology changes have had on the time for service provision. The Medical Services Payment Committee (a bilateral body with representation from the OMA and the Ministry) has previously been established through the 2004 and 2008 Physician Services Agreement. The Ministry is willing to work with the OMA on a review of the Schedule of Benefits.

4.7 Ministry Has Recently Acted on the Significant Increase in Echocardiography Services Billed

The total cost of cardiac ultrasound services (also called echocardiography) performed on patients in Ontario increased by 19% from approximately \$170 million in 2009/10 (for about 3 million procedures), to about \$202 million in 2014/15 (for about 3.6 million procedures). In June 2016, the Ontario Association of Cardiologists (Cardiologists Association) published an open letter to the Auditor General regarding its specific concerns over cardiac-care spending. (**Appendix 3** contains the letter.) We met with representatives from the

Cardiologists Association to gain an understanding of their concerns.

4.7.1 Duplicated Payments on Ambulatory Cardiac Rhythm Monitoring Tests Not Recovered

The Cardiologists Association's **first concern** was:

1. *"We believe that certain ambulatory cardiac rhythm monitoring tests were, and are being, inappropriately over-billed to OHIP. They have been paid for without question for a number of years, costing the system millions of dollars. This continues despite cardiologists' urging the Ministry in July 2015 to put a stop to this practice. The government's inactions have encouraged the proliferation of these inappropriate billings, wastefully increasing the cost of cardiac care while eroding its quality."*

Based on our further discussion with the Cardiologists Association, we noted that their concern referred specifically to the Ministry paying twice for the same cardiac rhythm monitoring test performed on patients; essentially, physicians were being double-paid for performing one test. We followed up on this concern and noted that the Ministry, which was aware it double-paid physicians for cardiac rhythm monitoring tests in October 2014, had taken steps to address it prior to our audit. However, the Ministry did not plan to recover the overpayments, as described in the following account:

- In October 2014, the Ministry became aware of fee-for-service claims related to two specific cardiac rhythm monitoring tests that were inappropriately claimed and paid to physicians. The Ministry determined that approximately 70 physicians were overpaid at least \$3.2 million between April 2012 and May 2015. However, at the time of our audit, the Ministry was not planning to recover any of the \$3.2 million it had made in duplicate payments.
- The Ministry noted that the inappropriate billing was being orchestrated by a third-party

company owned by non-physicians. The third-party company owned and supplied the technology used in the tests, and used the physicians' OHIP billing numbers to bill the Ministry on their behalf. The company then paid the physicians a portion of the fee. (Because this third-party company owned an advanced technology that can operate and monitor the test results even when patients are at home, this technology has made the test procedures much easier.)

- Upon the Ministry's request, the company stopped billing in this manner. In February 2016, the Ministry implemented changes to its billing rules to prevent further duplicate payments for these tests. We performed additional analysis after the new billing rules were implemented and noted further duplicate payments did not recur.
- The Ministry sent an OHIP bulletin to physicians in August 2015 to inform them of their responsibility to know what OHIP services are being billed in their name.

4.7.2 Cardiac Ultrasound Services Delivered by Commercial Lab Facilities Need More Oversight

The Cardiologists Association's **second concern** was:

2. *"In October 2015, the Ministry unilaterally decided to waive the longstanding requirement for a qualified physician to be present during the performance of cardiac ultrasound services. Quite predictably, this action has boosted the profits of commercial labs almost overnight. These labs provide services without a physician being present, and without regard to the appropriateness of these tests. Worse still, this Ministry decision has unleashed a flurry of new commercial interests whose sole goal is to drive-up utilization and maximize profits, further burdening the limited provincial health care budget."*

The Cardiologists Association questioned the Ministry's unilateral decision to change the fee for cardiac ultrasound services so that the same amount would be paid regardless of whether a physician was on-site performing the test, or off-site but still available to supervise. They criticized the decision for being made without adequate consultation with representatives from their specialty. The Cardiologists Association brought up two concerns:

- the decision has boosted the profits of commercial lab facilities; and
- these facilities provide services without regard to the appropriateness of the tests performed.

We asked the Ministry why it had made this change and obtained the following responses:

- The Ministry pointed out that the change was necessary to reflect advances in technological and remote access. A decade ago, when technology such as videoconferencing was not widely used, physicians' presence physically in a lab facility was necessary to ensure the appropriateness of the cardiac ultrasound services. As remote-communications technologies are now more commonly available, physicians' presence on-site may not be necessary for all services performed. This is especially true in remote areas where long-distance travel is a concern.
- The Ministry emphasized to us that appropriate physician supervision, although the physician might not be physically present, is still required to maintain the standards in performing cardiac ultrasound services. The supervising physician should still be within close proximity in case the physician present is required to care for a patient.

We noted, however, that before the Ministry made the decision, it had not done sufficient consultation with cardiologists, and that the change of requirement does increase the risk that cardiac ultrasound services could be delivered at commercial lab facilities without the presence of a cardiologist.

Profit Levels of Commercial Lab Facilities

With respect to the Cardiologists Association's concern over boosting the profits of commercial lab facilities, we reviewed billing data for echocardiographs from October 1, 2015 (the time when the change of requirement became effective) to March 31, 2016, and compared the volume of services to the same six-month period in the prior year (October 1, 2014, to March 31, 2015) to determine if the October 1, 2015, change to the billing rules had an impact on the number of services being performed. (As mentioned earlier, the Ministry changed the fees so that the same amount would be paid regardless of whether a physician was on-site performing the test or off-site but available to supervise.)

Our review of the Ministry's data found that the increase in the amount paid by the Ministry and the volume of services conducted was minimal—less than 0.1%. However, the Ministry should continue to monitor the volume of these services provided to ensure that only necessary services are being conducted with proper supervision.

In terms of whether the October 2015 change has led to the opening of more of lab facilities, the Ministry has no complete information to test this claim. The Ministry did not know how many lab facilities existed at the time and which were physician owned as opposed to commercially owned. Without sufficient information, the Ministry could not determine how many of the approximately 500 lab facilities operating now existed prior to the changed requirement or how many of them were newly opened as a result of the change. The Ministry funds the Cardiac Care Network (Network) to support the Local Health Integration Networks, hospitals and other care providers with the goal of improving quality, efficiency, access and equity in the delivery of the continuum of cardiovascular services in Ontario. Since April 2016, lab facilities that perform cardiac ultrasound tests are required to register with the new Echocardiography Quality Initiative program before they are paid by OHIP.

Appropriateness of Cardiac Ultrasound Tests Performed

With respect to the Cardiologists Association's concern over the appropriateness of cardiac ultrasound tests, we noted that the Ministry does not know which facilities are following appropriate standards or not, and it will not know until the new Echocardiography Quality Initiative program managed by the Network is proven to be effective in overseeing this service.

Because the Echocardiography Quality Initiative program has just started, at the time of our audit, the Ministry was not able to determine how effective the new program would be in deterring inappropriate use of echocardiography. In addition, the program does not apply to other preoperative cardiac tests, such as stress tests, chest x-rays, lung function testing and nuclear imaging, as explained in the next section.

4.7.3 Unnecessary Preoperative Cardiac Testing

Before the Cardiologists Association published their open letter to the Auditor General, we had analyzed cardiac care billing trends and volumes. Our audit found that the Ministry has had minimal success in attempting to control excessive preoperative cardiac testing.

Preoperative cardiac tests (procedures such as echocardiography, echocardiograms, stress tests, chest x-rays, lung-function testing and nuclear imaging) are performed before a patient undergoes surgery to examine if the heart is healthy enough to withstand surgery and anesthesia. National medical evidence shows that routine preoperative cardiac testing for patients undergoing low-risk surgery does not improve the outcomes of these surgeries. One of the recommendations of the Choosing Wisely Canada campaign is to avoid routinely performing preoperative cardiac testing on patients undergoing low-risk surgery.

In 2012, the Ministry identified preoperative cardiac tests as an area for potential savings. The

Ministry targeted savings of \$43.7 million for 2013/14 by reducing the number of unnecessary preoperative cardiac tests for patients undergoing low- to moderate-risk non-cardiac surgery. The actual savings were \$700,000—\$43 million short of the target—and were achieved through increasing physicians' awareness that preoperative cardiac tests were being overused. The Ministry later calculated that, for the fiscal year 2014/15 alone, approximately \$35 million was paid to physicians for up to 1.15 million preoperative cardiac tests for low-risk surgeries that may not have been medically necessary.

As mentioned earlier, the Cardiac Care Network of Ontario has just started the Echocardiography Quality Initiative program to evaluate and assess the quality of echocardiograms performed by facilities. At the time of our audit, the Ministry was not yet able to determine how effective the new program, which was made mandatory in April 2016, would be in deterring inappropriate use of echocardiography.

RECOMMENDATION 12

To strengthen the oversight of the use of cardiac ultrasound services, the Ministry of Health and Long-Term Care should work with the Ontario Association of Cardiologists and the Cardiac Care Network of Ontario to:

- assess the effectiveness of the Cardiac Care Network of Ontario's Echocardiography Quality Initiative program intended to deter inappropriate use of cardiac ultrasound services;
- monitor the use of cardiac ultrasound services claimed by facilities, such as those owned by non-physicians, and take corrective actions when anomalies are identified; and
- recover the \$3.2 million of over payments to physicians related to the cardiac rhythm monitoring tests that were inappropriately claimed.

MINISTRY RESPONSE

The Ministry welcomes this recommendation and will work with the Cardiac Care Network and professional organizations to assess the effectiveness of the accreditation process. The Ministry will continue to monitor the use of cardiac ultrasound services (echocardiograms) and take action where there are anomalies.

The Ministry will work with the Ontario Association of Cardiologists and the Cardiac Care Network to assess the impact of the Echocardiography Quality Initiative in ensuring that best-practice quality standards are applied in echocardiography service provision and that Ontario patients are receiving safe and appropriate care.

The Ministry acknowledges the third recommendation, but currently does not have authority to directly recover the estimated \$3.2 million. The current process required to recover funds, under the conditions described in the *Health Insurance Act*, is described in **Figure 18** (Ministry of Health and Long-Term Care's Fee-for-Service Billing Review Process). The Ministry will review its options under the *Health Insurance Act* to determine the appropriate course of action regarding this particular recommendation.

4.8 Medical Liability Protection Costs Are Rising

4.8.1 Taxpayers Have Paid \$567 Million over the Three Years from 2013 for the Rising Cost of Medical Liability Protection

Over the past few years, physicians' medical liability protection costs in Ontario have risen dramatically—and they are continuing to rise. The Ministry and taxpayers have had to bear the responsibility for these significant cost increases.

The Canadian Medical Protective Association provides legal advice and defence to physicians

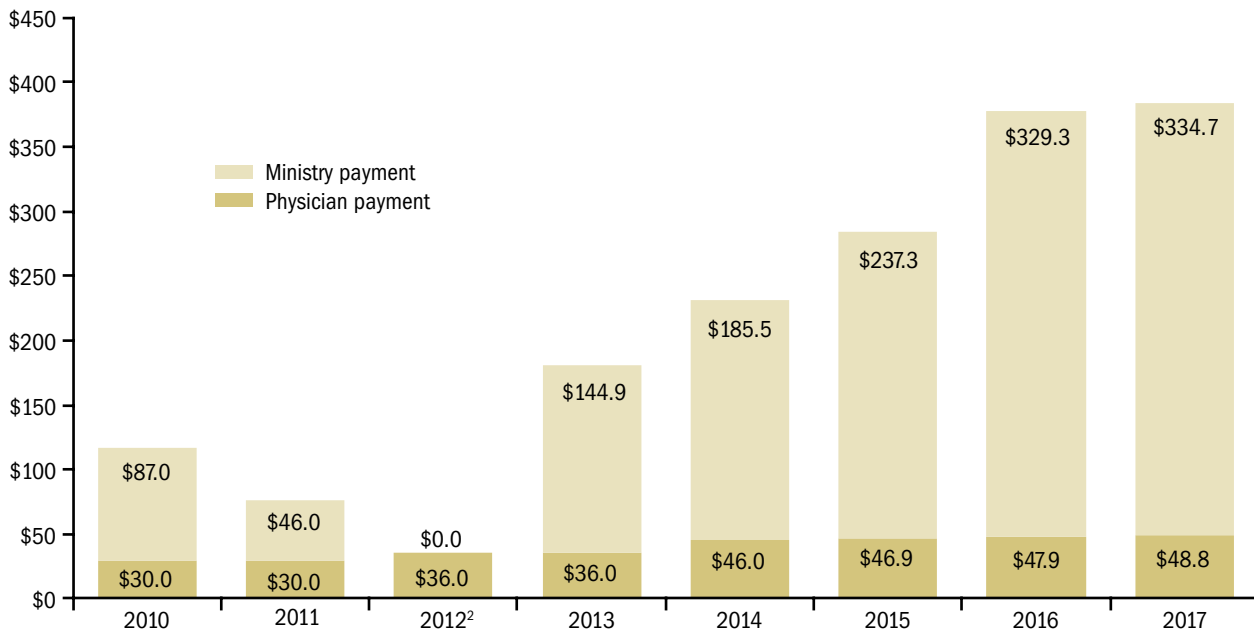
when medical–legal issues arise in their work. It also provides compensation to patients and their families who have been harmed by negligent care. The types of medical–legal difficulties the Canadian Medical Protective Association can assist physicians with include civil legal actions resulting from negligent care, complaints from the College of Physicians and Surgeons of Ontario and/or from hospitals, Ministry billing reviews and inquiries, human rights issues, criminal matters resulting from the practice of medicine and coroner's inquests. Unlike the United States, where physicians are responsible for paying for their own medical liability protection costs, all Canadian provinces, including Ontario, reimburse a portion of the costs. These reimbursement arrangements have been negotiated by the respective ministry and provincial medical association in lieu of other forms of compensation for clinical work.

Medical liability protection costs have been fluctuating since 2010, although the trend is a steep rise. Total membership fees decreased by 69% from \$117 million in 2010 to \$36 million in 2012, and then dramatically increased to \$284.2 million in 2015—almost eight times higher than 2012 levels. The Canadian Medical Protective Association's 2017 membership fees in Ontario will be approximately \$380 million. **Figure 20** shows the recent fluctuations and gives a breakdown of Ministry and physician portions of the membership fees.

The Ministry's contributions have fluctuated from nil in 2012 to about \$329 million for 2016. We noted that for 2012 the Ministry exercised a provision of an arrangement between the Ministry, the OMA and the Canadian Medical Protective Association to use a large portion of a temporary surplus to reduce the annual membership fees for that year. However, the total membership fees were subsequently increased to address the resulting funding deficit and the rising medical liability protection costs reported by the Canadian Medical Protective Association. (Other reasons for the rise in medical liability costs are increases in legal costs to defend physicians and compensate patients.) The

Figure 20: Ontario Physicians and the Ministry of Health and Long-Term Care's Payments for Medical Liability Protection¹ (\$ million)

Sources of data: The Ministry of Health and Long-Term Care; the Canadian Medical Protective Association



1. The allocation of payment between physicians and the Ministry is stipulated in a tripartite memorandum of understanding between the Ministry, the OMA and the Canadian Medical Protective Association and in a previous Physician Services Agreement for years 2010–2013, and in the 2012 Physician Services Agreement for years thereafter.
2. The Ministry's portion is zero in 2012 because the Canadian Medical Protective Association used the temporary surplus in its reserves to reduce its annual membership fee, and the total aggregate fee requirement of \$36 million was paid entirely by physicians.

Ministry's portion of the membership fees has risen and is expected to be \$335 million, or 87% of the total membership fees, in 2017.

In contrast, the physicians' portion of the contribution remains relatively stable, because over the last two decades the Physician Services Agreements have stipulated the amount of the membership fees to be paid by physicians. Because the rest is paid by the Ministry, it is the government that is responsible for bearing the costs of membership fees increases.

Ontario is not alone in reimbursing medical liability protection costs—all other provinces have a similar system in place. The percentage of the membership fees other provinces pay is not reported publicly, although based on our analysis of available information, Alberta and Saskatchewan both contribute over 85% of the membership fees, which is comparable to Ontario. However, we found that Ontario's dollar expenditure for medical liabil-

ity protection costs, about \$8,400 per physician in 2015/16, is 50% higher than what Alberta spends (\$5,600 per physician) and almost double what British Columbia spends (\$4,400 per physician). This reflects the higher costs of providing medical liability protection in Ontario. British Columbia and Saskatchewan are the only provinces that limit the total funding the government will put toward the protection costs, by specifying in their agreements with their physicians that physicians will share ongoing cost increases to medical malpractice protection.

A large majority of the physicians who responded to our survey, 90%, indicated that the Ministry should continue to substantially subsidize medical liability protection costs; the remaining 10% disagreed.

4.8.2 A Joint Effort between the Ministry, the OMA and the Canadian Medical Protective Association to Control Rising Liability Protection Costs Is Long Overdue

A joint effort between the Ministry, the Ontario Medical Association and the Canadian Medical Protective Association is required to review the legal context surrounding the dramatic increase in medical malpractice trends. Such a review is long overdue.

Although escalating medical malpractice costs were seen as a problem as early as the 1980s, at the time of our audit both the Ministry and the Ontario Medical Association have not taken the measures needed to control these costs. As far back as 1988 a Ministry-appointed lawyer stated that a responsible and effective review of the legislative areas relating to medical malpractice trends was long overdue, and that the delay was costing the public. However, when in 1995 the Canadian Medical Protective Association engaged a third-party consultant to review its operations amidst talk of the Ministry removing its contribution, the resulting report supported the status quo. As a result, the Ministry continued to pay the large fee increases that followed.

In both the 1997 and 2000 Physician Services Agreements, however, the Ministry and the Ontario Medical Association agreed on the urgent need to examine all the available alternatives for medical liability protection coverage. Both parties agreed on the importance of identifying alternative methods of providing coverage and considering reform of the law with respect to malpractice claims (for example, setting procedural limits on how claims can be filed and placing caps on the amount of damages that can be awarded). Similar issues were discussed in the 2004, 2009 and 2012 Physician Services Agreements, again emphasizing the need for legal reforms. However, senior representatives from both the Ministry and the Ontario Medical Association have confirmed that their discussions during the 2012 negotiations did not focus on protection costs.

Nevertheless, in March 2016, the Ministry retained a third-party consultant to carry out a

review and make recommendations on how to reduce medical liability protection costs, improve the efficiency of the civil justice system with respect to medical liability, and ensure that plaintiff-patients in medical malpractice cases receive appropriate compensation in a timely manner. The draft report and recommendations are due to the Ministry by December 1, 2016, and the final report is due by January 15, 2017. Meanwhile, Canadian Medical Protective Association membership fees are higher in Ontario than in any other province. For example, the annual fee for a physician practising in obstetrics is close to \$72,500 in Ontario, compared to \$55,100 in British Columbia and Alberta, \$34,200 in Quebec, and \$27,700 in all other provinces and territories. **Figure 21** breaks down annual Canadian Medical Protective Association membership fees for selected different types of work by region.

RECOMMENDATION 13

To address the rising costs of medical liability protection, the Ministry of Health and Long-Term Care should work with the Canadian Medical Protective Association and the Ontario Medical Association to review the recommendations of the third-party report when it becomes available in early 2017, and take any necessary actions in an effort to reduce the cost burden on taxpayers.

MINISTRY RESPONSE

The Ministry welcomes this recommendation and looks forward to receiving the third-party report and its recommendations to reduce medical liability protection costs in Ontario. The Ministry will work with the Canadian Medical Protective Association, the OMA and other stakeholders to review the report's recommendations and to take the necessary actions to reduce medical liability protection costs while ensuring that patients receive appropriate compensation in a timely manner and that health-care institutions and health-care providers are accorded fair processes.

Figure 21: Annual Canadian Medical Protective Association Membership Fees by Regions and by Selected Types of Work Performed by Physician, 2016

Source of data: Canadian Medical Protective Association

Type of work ¹	Ontario (\$)	British Columbia and Alberta (\$)	Quebec (\$)	All Other Provinces and Territories (\$)
Geriatric medicine	2,300	2,100	1,800	1,700
Medical oncology	3,000	2,100	2,300	1,800
Family medicine excluding certain types of work ²	4,400	3,600	1,900	2,100
Cardiology	5,000	4,200	2,800	2,300
Respirology	5,000	4,200	2,800	2,300
General pathology	7,700	5,300	5,100	4,200
Anesthesiology	12,300	10,800	6,100	4,700
Emergency medicine	12,300	10,800	6,100	4,700
Pediatric surgery	19,500	18,400	12,300	8,900
Vascular surgery	19,500	18,400	12,300	8,900
Obstetrics	72,500	55,100	34,200	27,700

1. There are more than 60 types of work specified by the Canadian Medical Protective Association. This list only includes selected types of work.

2. Excludes certain types of work: anesthesia, obstetrics, shifts in emergency departments and surgery.

4.8.3 Paying Physicians' Legal Costs in Billing Reviews Could Put the Ministry in a Conflict of Interest

In some cases, when the Ministry reviews physicians' billings and asks the physicians to provide medical records to support and verify their claims, the physicians may request assistance from the Canadian Medical Protective Association in defending their billing practices, including legal support for most serious cases. As it is the Ministry that pays for the majority of the amount of liability protection costs, we see this as a potential conflict of interest, because the Ministry has a reduced incentive to investigate wrongdoing if it must pick up part of the tab for the physicians' legal costs. The Ministry does not know the number of times that physicians request legal assistance from the Canadian Medical Protective Association lawyers during billing reviews, or the associated legal costs.

For example, during our review of the Ministry's review of physicians' billings, we came across letters from physicians' legal counsel replying directly to the Ministry on behalf of their clients. We were

not able to assess which parties had paid the cost of these legal services, because the Ministry does not know if these are lawyers provided by the Canadian Medical Protective Association, or the physicians' own lawyers paid for out of pocket. The risk is that these lawyers are provided by the Canadian Medical Protective Association and thus paid for by taxpayer funds.

RECOMMENDATION 14

To avoid being placed in a conflict of interest when investigating physicians' billings, the Ministry of Health and Long-Term Care should work with the Canadian Medical Protective Association and the Ontario Medical Association to ensure that taxpayer funds are not being used to reimburse physicians for membership fees due to the Canadian Medical Protective Association for the use of lawyers provided by the Canadian Medical Protective Association to assist physicians with Ministry billing reviews.

MINISTRY RESPONSE

The Ministry supports this recommendation. The Ministry reimburses physicians for a portion of their Canadian Medical Protective Association (CMPA) membership fees, and historical tripartite Memorandums of Understanding (MOUs) between the Ministry, the CMPA and the OMA (including the most recent MOU) outlined that any increase in the Ministry's subsidy would exclude changes associated with defending fee disputes between an Ontario physician and the government or criminal matters involving an Ontario physician. In conjunction with the recommendations provided in the third-party report to be received in 2017, the Ministry will review the issue of whether taxpayer funds are being used to reimburse physicians for CMPA fees related to CMPA assistance with Ministry billing reviews.

Appendix 1: Summary of Fee Changes as per Physician Services Agreements of 2004, 2008 and 2012, and Other Reductions from April 1, 2014, to Present

Source of data: Ministry of Health and Long-Term Care

2004 Physician Services Agreement (Effective between April 1, 2004, and March 31, 2008)			
	2004/05	2005/06	2006/07
Effective date	Between April 1, 2004, and March 31, 2008 ¹	Between April 1, 2005, and March 31, 2008 ¹	n/a
Fee change	2.5% increase to all family practice professional fees 2% increase to all specialist professional fees Targeted increase to over 600 fee codes in the Schedule of Benefits	1% increase to all technical fees	No change No change
2008 Physician Services Agreement (Effective between April 1, 2008, and March 31, 2012)			
	2008/09	2009/10	2010/11
Effective date	Between October 1, 2008, and September 30, 2009 ¹	October 1, 2009	October 1, 2010
Fee change	3% global increase to all physicians	5% targeted increase ²	3% targeted increase ²
No agreement between April 1, 2012, and September 30, 2012			
2012 Physician Services Agreement (Effective between October 1, 2012, and March 31, 2014)			
	2012/13	2013/14	2011/12
Effective date	n/a	April 1, 2013	September 1, 2011
Fee change	No change	0.5% global decrease to all physicians	4.25% targeted increase ²
No agreement since April 1, 2014			
Ministry's Fee Reduction—April 1, 2014, to Present			
	2014/15	2015/16	2016/17
Effective date	February 1, 2015 and June 1, 2015	October 1, 2015	To be determined ³
Fee change	2.65% global decrease to all physicians	1.3% global decrease to fee-for-service billings Targeted decrease to over 200 fee codes in the Schedule of Benefits	1% decrease for professional fee billings above the first \$1 million

- This change was only applicable for the specified period. Fees reverted to the original level after period end.
- The "targeted increase" was applied only to specific fee codes in the Schedule of Benefits for Physician Services, as recommended by the Medical Services Payment Committee. Allocations to each clinical section were described in Section 3 of the 2008 Physician Services Agreement.
- This change has not been implemented at the time of our audit.

Appendix 2: Physician Compensation Models Used in Different Jurisdictions

Prepared by the Office of the Auditor General of Ontario

	Advantages	Disadvantages	Examples and Prevalence
<p>Fee-for-Service Model: Physicians are paid based on the type and number of services they provide to patients (e.g., physical exam, consultation, surgery). Each service has a specified fee.</p>	<p>Patient perspective</p> <ul style="list-style-type: none"> • Patients do not have to enroll or sign up with any one specific physician • Can increase the likelihood of unnecessary testing on patients • Incentivizes high volume of services, which may not equate to quality care <p>Service provider perspective</p> <ul style="list-style-type: none"> • Allows physicians to handle their own billings and can target their own incomes, which provides autonomy • There are no monetary incentives to encourage a physician to engage in continuing professional development or to spend time on quality improvement <p>Administrator perspective</p> <ul style="list-style-type: none"> • Provides the administrator with important data regarding specific services' utilization rates in order to assist in planning and decision-making • Can increase the likelihood of unnecessary testing leading to over-servicing and increased cost • Does not allow for a predictable budget 	<p>Per-Patient Base (for family physicians): Physicians are paid based on the number of patients enrolled for a basket of services under their care. There is a specified annual payment for each patient depending on factors such as age and gender.</p> <p>Patient perspective</p> <ul style="list-style-type: none"> • Physicians focus more on patient health outcomes than volume of services • Physicians may not enroll high-needs patients, particularly when enrolment payments are not adjusted for the complexity of patients' needs and for multiple medical conditions • Ontario, Quebec, British Columbia and Alberta's primary care models include enrolment-based payments for their family physicians <p>Service provider perspective</p> <ul style="list-style-type: none"> • Allows physicians more time to focus on managing complex conditions • Physicians must abide by the terms of their contract with the administrator • Medicare in the United States is mostly fee-for-service but is moving toward a per-patient base system <p>Administrator perspective</p> <ul style="list-style-type: none"> • Incentivizes physicians to control services provided, which minimizes unnecessary testing or over-servicing • Data regarding types of services performed may be lacking if the physicians do not report all the services performed • Allows for a more predictable budget 	

Advantages	Disadvantages	Examples and Prevalence
Alternative Payment Plans: Physicians sign a contract with the Ministry to provide agreed-upon services. Alternative payment plans differ and can include a blend of payment models including fee-for-service, salary, bonuses and other incentives.		
<p>Patient perspective</p> <ul style="list-style-type: none"> • Patients in under-served areas benefit from increased recruitment and retention <p>Service provider perspective</p> <ul style="list-style-type: none"> • Enhances income predictability and stability for physicians • Physicians are compensated for providing training to new physicians as a result of decreased clinical hours 	<ul style="list-style-type: none"> • No direct disadvantage noted • Physicians must abide by the terms of their contract with the administrator 	<ul style="list-style-type: none"> • Ontario uses alternative payment plans to encourage physicians to provide certain services, such as academic services, (including training new physicians and conducting research) as well as to provide emergency services in hospitals and to work in remote areas • Alberta and British Columbia have similar alternative payment plans
<p>Administrator perspective</p> <ul style="list-style-type: none"> • Plans can be designed to address the changing needs of patient health care • May increase the recruitment and retention of physicians in under-served areas or needed sub-specialties (e.g., pediatrics and geriatrics) 	<ul style="list-style-type: none"> • Data regarding types of services performed may be lacking if the physicians do not report all the services performed 	
Salaried Physician Model: Physicians are paid a salary by the organization that they work for and are employees of that organization.		
<p>Patient perspective</p> <ul style="list-style-type: none"> • Little risk to patients of unnecessary procedures, since physicians are not incentivized to increase volume of services 	<ul style="list-style-type: none"> • No incentive to be more productive or focus on patient health outcomes, as salary is fixed 	<ul style="list-style-type: none"> • Ontario physicians who practise in Community Health Centres are paid salaries, as they are employees of the organization
<p>Service provider perspective</p> <ul style="list-style-type: none"> • No overhead costs for physicians • Physicians able to participate in continuing professional development 	<ul style="list-style-type: none"> • Physicians must abide by the terms of their employment contract with the administrator 	<ul style="list-style-type: none"> • Physicians practising within Kaiser Permanente in the United States • Majority of family physicians in Sweden • Specialists in the United Kingdom
<p>Administrator perspective</p> <ul style="list-style-type: none"> • Funder is able to manage budget • Encourages efficiencies through the use of other health professionals in a multidisciplinary setting • Rewards physicians who stay at facility through increases in salary 	<ul style="list-style-type: none"> • Responsible for overhead expenditures, staffing, pension, vacation and other benefits 	

Advantages

Disadvantages

Examples and Prevalence

Pay-for-Performance Model: Physicians are rewarded financial incentives for meeting certain performance targets.

<p>Patient perspective</p> <ul style="list-style-type: none"> Improves patient outcomes, as long as physicians' compensation is tied to appropriate measures of quality care 	<ul style="list-style-type: none"> Physicians may choose patients whose health outcomes are likely to improve 	<ul style="list-style-type: none"> Family physicians in the United Kingdom California has the largest pay-for-performance program in the United States Medicare in the United States
<p>Service provider perspective</p> <ul style="list-style-type: none"> Rewards physicians financially based on a point system, which can include criteria such as patient outcomes, access to care, time spent with patients, etc. 	<ul style="list-style-type: none"> May undermine a physician's role to always focus on the patient first if points are not based on appropriate patient outcomes Physicians may be penalized by uncontrollable factors such as patients' unwillingness to improve their health conditions 	
<p>Administrator perspective</p> <ul style="list-style-type: none"> Funder is achieving value for payments made to physicians 	<ul style="list-style-type: none"> The point system relies on physicians' self-reported data Collection of outcome data could be expensive 	

Appendix 3

Open Letter from the Ontario Association of Cardiologists:



An Open Letter to the Auditor General of Ontario

Re: Ministry of Health and Long-Term Care Misuse of Public Resources

Bonnie Lysyk
CPA, CA, LPA, MBA
Auditor General of Ontario
20 Dundas Street West
Suite 1530
Toronto, ON M5G 2C2

June 7, 2016
Dear Ms. Lysyk,

The Ontario Association of Cardiologists (OAC) is calling on you, as the chief observer of provincial government fiscal accountability, to immediately undertake a review of the Wynne government's cardiac care spending, through the Ministry of Health and Long-Term Care (Ministry), and to report on what we consider to be the serious misuse of public resources.

As physicians and taxpayers, we are turning to you as a measure of last resort, having exhausted all avenues of reasonable discourse with Ministry officials. Our message to these officials has been clear and consistent. The Ontario government's unilateral actions of 2012 and 2015 have resulted in a lower quality of care at higher cost and increased utilization. These actions threaten the long-term viability of the health care system.

We are asking you to examine two issues involving cardiac tests. These are the most glaring examples of poor management, having been left completely unregulated for decades, despite persistent calls by cardiologists to regulate them.

1. We believe that certain ambulatory cardiac rhythm monitoring tests were, and are being, inappropriately over-billed to OHIP. They have been paid for without question for a number of years, costing the system millions of dollars. This continues despite cardiologists' urging the Ministry in July 2015 to put a stop to this practice. The government's inactions have encouraged the proliferation of these inappropriate billings, wastefully increasing the cost of cardiac care while eroding its quality.
2. In October 2015, the Ministry unilaterally decided to waive the longstanding requirement for a qualified physician to be present during the performance of cardiac ultrasound services. Quite predictably, this action has boosted the profits of commercial labs almost overnight. These labs provide services without a physician being present, and without regard to the appropriateness of these tests. Worse still, this Ministry decision has unleashed a flurry of new commercial interests whose sole goal is to drive-up utilization and maximize profits, further burdening the limited provincial health care budget.

The people of Ontario need to be concerned that the Wynne government's mismanagement of health care is resulting in higher costs and lower quality care. We therefore request that you review these ill-conceived decisions that endanger lives and the sustainability of cardiac care in Ontario.

Respectfully,

James Swan, MD, F.R.C.P.(C) F.A.C.C.
President, Ontario Association of Cardiologists

c.c. Hon. Kathleen Wynne, Premier of Ontario
Mr. Patrick Brown, Leader, Official Opposition
Ms. Andrea Horwath, Leader, New Democratic Party of Ontario

Ontario Association of Cardiologists
34 Eglinton Ave. West, Suite 410
Toronto, ON M4R 2H6
Tel: 416-487-0054
Fax: 866-554-4347
Toll-Free: 877-504-1239

The Ontario Association of Cardiologists is a voluntary professional organization representing Ontario cardiologists. Our board and members work each day with the provincial government, the Ontario Medical Association and the Ministry of Health and Long-Term Care to advocate for the specialty of Cardiology, to maintain and improve the quality of cardiac care in Ontario.

ontarioheartdoctors.ca

Appendix 4: Selected Patients' Satisfaction Survey Results, October 2014–September 2015

Source of data: Ministry of Health and Long-Term Care

Selected Survey Questions	Patient Responses	
	Always/Often (%)	Sometimes/Rarely/Never (%)
When you see your provider or someone else in their office, how often do they know important information about your medical history?	84	16
When you see your provider or someone else in their office, how often do they give you an opportunity to ask questions about recommended treatment?	85	15
When you see your provider or someone else in their office, how often do they spend enough time with you?	82	18
When you see your provider or someone else in their office, how often do they involve you in decisions about your care?	86	14
When you see your provider or someone else in their office, how often do they explain things in a way that is easy to understand?	92	8

Note: The Ministry of Health and Long-Term Care uses information collected from the Health Care Experience Survey (Survey) to better understand Ontarians' interactions with the health-care system. The Survey is a telephone survey given to a sample of Ontarians aged 16 years and older. Respondents are asked questions, among others, about their experiences with primary care and about integration of specialist with primary care. Only the selected questions regarding patients' experiences with primary care are included in this Appendix.

Appendix 5: International Comparison of Selected Survey Results among Ontario, Canada and Other Developed Countries, 2014

Source of data: The Commonwealth Fund 2014 International Health Policy Survey

Selected Survey Question	Canadian Comparison			International Comparison		
	Ontario Average (%)	Canada Average (%)	How Ontario Compares to Other Canadian Provinces	Commonwealth Fund Average* (%)	How Canada Compares to the Commonwealth Fund Average	How Ontario Compares to the Commonwealth Fund Average
% of patients who saw their physician on the same or next day	44	41	Rank 2 of 10	62	Rank 11 of 11	Worse
% of patients who thought it was very or somewhat difficult to get medical care in the evenings and on weekends or holidays without going to the emergency department	47	51	Rank 2 of 10	29	Rank 11 of 11	Worse
% of patients who went to an emergency department for a condition that could have been treated by the regular physician	39	37	Rank 7 of 10	28	Rank 10 of 11	Worse

* The Commonwealth Fund surveyed 11 countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States.