A. **RECALIBRATE BASE CAPITATION RATES FOR FHOs**
**MOH Position:** reduce base rate payouts by 25%!

This is plain and simple a money grab that is, an attack on lady physicians, and not surprisingly, short-sighted and fails to appreciate why more money was invested in these models in the first place and why it is necessary to keep it there.

**Some background is needed:** It started in the early 1990's when Bob Rae's NDP Party (yes, they actually got into power) under their "Social Contract" decided that the best way to take control of health budgets was to "negotiate" a 10% fee reduction with the OMA (members' confidence in the OMA deteriorated and new groups trying to represent doctors started forming) and limit those who billed OHIP (this is similar to firing the weatherman because you don't like the weather). Medical school positions were frozen, FFS rates were reduced and frozen, billing caps with serious clawbacks were implemented, all during a period Ontario's population was growing and with it, an expected increase in demand for healthcare. The ensuing PC government of Mike Harris (1995-2002) under the banner of "Common Sense Revolution" created a common mess in medicine, particularly in Family Medicine, which became such a pitiful choice for future residents that few of them chose it. In fact, Family Doctors were actually leaving the Province for other provinces or moving to the US. By the time Dalton McGinty Liberals came to power (2003-13), Ontario had a serious shortage of Family Doctors, something the OMA and doctors had been warning about for years. A similar pattern is starting to take shape in the UK, the country that was ranked #1 overall in health delivery but is now showing some cracks in its treatment of its General Practitioners.

Around 2005, money started, rightly, flowing back into Family Medicine; and eventually, medical students, many female, started choosing Family Medicine as their first choice of specialty. In addition, to try to fix the shortage of Family Physicians created by the NDP and PC governments, positions at medical schools were increased and new avenues were created for foreign-trained MD to be certified in Ontario. The McGinty Government also passed a new health tax to help pay for many new initiatives.

The MOH now wants to slash these needed investments to such an extent that it will severely limit the care that Ontarians will receive. This will not be good for anyone except for the Bay Street pigs that Premier Doug Ford will eventually force onto his side by lightening their relatively small tax burden even more (more tax breaks for the rich). If the PCs are successful in implementing the slashing of these investments, it will set Family Medicine back 25 years!

Additional investment was also made to help physicians adopt EMRs – something that was deeply lacking in Ontario, compared to other jurisdictions, and was seen as an important step in proving effective primary care. Funding for EMRs has since been virtually eliminated.

**An attack on lady physicians:** Around 1995 female medical students (50.6%) outnumbered males in Canadian Medical Schools. Women's share has increased steadily such that in 2016-17 female medical students were exceeding 56% of medical schools. This dominance by women had its start in the 1960s, but within 30 years the medical landscape changed from a mostly male-dominated profession to one that will soon change to a mainly female-dominated profession. It is not surprising, now that lady physicians are beginning to dominate an area of medicine, that the "value" must not be as high as other areas. Grim observation, unfortunately this is a worldwide phenomenon (see The New York Times and *The Atlantic*). We are disgusted by it, but sexism is prevalent in medicine and often hides behind seemingly reasonable positions such as "I'm not sexist, I expect the same from all my physicians" (That is, pregnant physicians do not get a special break, even though we might ask employers of our expecting mother for modified duties; physicians who want reduced hours to care for kids are not pulling their weight etc.). Read about a recent report on sexism in the ED of a couple of Ontario hospitals.

Get ready ladies, you're just about to get discounted!

B. **INCREASE TO [THE] FHO MANDATORY GROUP SIZE**
**MOH Position:** All PEM groups will have to have at least 6 members with a shared EMR.

The MOH's reason for this appears to be to try to make sure that FHOs are sufficiently large that after-hours coverage is met. I believe this is a red herring. I don't see why a group of three or four doctors can't take care of after-hours, and I am sure many are. I am going to be more cynical in interpreting the MOH's position and suggest that this is a ploy aimed at reducing the number of physicians in FHO models. It is not a coincidence that this is the second issue on the list, right behind their proposal to slash fees. There is no provision in their proposal for 2 or more smaller FHOs, in the same geographic area, to be able to merge into a larger entity and maintain their FHO designation. The MOH wants to reduce the number of physicians in FHOs and they are hiding it behind the paternalistic notion that they know better when it comes to providing after-hours services.

This approach will backfire. Doctors forced out of the FHO model, who have clearly chosen this model, will be forced back to FFS models if they cannot be allowed to merge with other local FHOs or if there aren't any FHOs nearby. It will be back to never-ending visits to the doctor's office. Medicine will be meted out in small portions and patients will suffer.

The requirement that all FHO members need to have a shared EMR is simply not practical and is expensive. You can't legislate the same EMR when the Provincial government allowed the marketplace to decide which EMR would flourish; what we have is an open marketplace with its expected competition and consolidation. The Provincial Government has not even set a standard for EMR's used at hospitals; entities that they control, yet now it tries to force standards on ***private*** medical clinics. Other countries rolled out national standards for EMR, for which they funded totally. In Canada, where healthcare is a provincial responsibility, we chose to do it differently.

C. **DAYTIME HOURS REQUIREMENTS**

**MOH Position:** Doctors will be expected to have office hours based on size of roster. The MOH is dictating the number of 4-hour units as well as the time of day that they must be available.

If this is an attempt by the Government to reign in any doctor/FHO that might be taking advantage of the circumstances by reducing weekly office hours significantly or for long periods of time during the year and relying on non-affiliated clinics to shoulder the responsibilities of attending to their roster, we do not have any objections to this intent. However, how it is being implemented does not support our preference to maintaining our independence.

There are three main problems with this micromanagement approach, which is being interpreted as a move by Government to try to wrest more control from doctors.

1. It violates the 1962 Saskatoon Agreement that allows doctors to be ***independent*** contractors while still participating in a government-run health system. That was the deal, honour it. Most doctors do not want to become government employees. That was the fear in 1962 and it still resonates with us today. Government is stepping outside of its jurisdiction when it tries to set offices schedules; when to work (they are already trying to control where we work) and the minimum patient volume that must be seen, face-to-face, per hour. This is exactly what many doctors were afraid of when new modes of

funding were introduced; now it appears the Government is trying to do just that.

2. The volume of patients that doctors can manage in a given period of time varies tremendously. Whereas some doctors, even if working full-time can never manage a roster do 1,300 patients others would be bored if their roster size was not 3,000 or more.

3. Models such as FHOs offer the opportunity to manage the health of the population as opposed to the individual. For example, running flu clinics by allied staff is much more efficient than having the doctor deal with flu shots at an appointment. Conversely, bundling (adding more services) medical issues in an appointment rather than bring the patient back for each issue extends the appointment time but efficiencies are gained in that fewer future appointments are needed for each patient. Or providing patients with test requisitions after reviewing consults or other test results, without seeing the doctor. The Government's approach to managing the doctor's time/volume is at odds with many of the efficiencies that FHOs can adopt.

And it's not that there is a lack of evidence that supports efficiencies with FHO models. According to Marchildon GP *et al.* (2016)[i] compared to other Provinces, that did not invest as heavily into primary care, "…*Ontario's primary care reforms may be starting to bear fruit in terms of access…*" (Pg. 735). Ontarians were more likely to have a regular family doctor (91% vs 84% Canadian avg.), more likely to be able to get an appointment within 2 days (35% vs 29%), more likely (no splits were published) to provide same or next day appointments to "almost all" or "most" of their patients and more likely to be able to provide after hours services thus avoiding local hospital emergency departments.

Kiran T, *et al.* (2014)[ii] reported that even without financial incentives, Ontario physicians in capitation models were screening for cervical, breast and colorectal cancers at rates 1.46, 1.40 and 1.43 higher compared to their FFS counterparts; evidence that the *model* was changing the behaviour of physicians.

Finally, the 2017 Commonwealth Fund[iii] report rated Canada 1st (out of 11 countries in the study) in nine Preventative Care indicators (see Appendix 2A: Preventative Care, pg. 18), so, as a country, our system works.

Government should stay out of the management of private doctors' offices.

D. **FHO AFTER HOURS REQUIREMENT**

**MOH Position:** After-hours coverage of min. 3 hours weekday and 3 hours every 3rd

weekend for every 1,300 patients.

Agreed. If you are in a FHO model and have 1,300 patients, you are only being asked to do 1 evening a week and one weekend shift (3 hours) every 3rd weekend. Again, agreed.

E. **END THE PATIENT ENROLMENT MODEL (PEM) AFTER-HOURS EXEMPTION**
**MOH Position:** Eliminate after-hours exemptions to FHN and FHOs

Not sure what the issues are. I suspect that the number of exemptions or how some groups have qualified have evolved into a state that was never intended. Maybe the rules for giving exemptions should be looked at and improved. Still, as with many situations there will be a need for verifiable, reasonable exemption. For example, if in a rural community the local MD's are obligated to work shifts at the local ED, then there should be some accommodation.

F. **REQUIREMENT FOR PROMPT ACCESS TO APPOINTMENTS FOR ACUTE CONCERNS**
**MOH Position:** FHO doctors are to provide care for their colleague's patients.

We are not sure why these have become an issue. FHO's are to provide services to ALL patients in the FHO. Simply adjusting how one books patients and FHO doctors paying each other can remedy this issue. If there are FHO members who simply refuse to see a colleague's patient, because they prefer to work as an island, they should do the honourable act and resign from the FHO. FHOs ARE ABOUT TEAMWORK. Agree with the MOH.

G. **ADJUST THE MAXIMUM SPECIAL PAYMENT (MSP) TO REDUCE OUTSIDE USE (FHO & FHN)**
**MOH Position:** When patients choose to visit another medical facility, the rostering MD will pay for it.

Again a money grab that is not well thought out, but then again, this Government's goal is to eviscerate the medical profession, so "thinking" is not part of the process (the objective is identified by the Minister of Health, (Hon.) Christine Elliott here.

The notion that MDs have control over where a patient chooses to get medical care is absurd. It has little to do with availability or office hours. Patients will visit other clinics for a variety of reasons, including, geographic convenience (just across the street, near work), time convenience (the wait time at the MRP's clinic is longer than at the walk-in

down the street), “I just go to whichever clinic is available”, patients that are using services of focused practices such as methadone clinics, pain clinics, sleep clinics and psychotherapy, which for some reason, are still considered part of the basket.

If this is passed, MDs would be saddled with massive overhead in just trying to minimize the clawbacks by continually de-rostering patients who use methadone clinics, pain clinics, those who use psychoanalysis, and those who find it hard to always travel to their MRP’s office. In effect, the more needy patients in the community would have to be orphaned; totally contrary to the MOH’s own goals of reducing the number of orphaned patients, totally contrary to any ethical discussion about patient care.

Doctors would now be faced with the prospect of informing some patients that they are no longer registered at the clinic, and possibly not be served there (see Section L, below). De-rostering and still serving them would not be easily done in this new environment for 2 reasons: 1. Remuneration for serving patients rostered elsewhere (which could be the case for these de-rostered patients) would be only 75% of an amount that has not been increased for too many years to count. We’re talking about rates not seen in more than 15 years! 2. In addition, with more of an MRP’s patients forcibly de-rostered, there would be more close encounters with the FHO’s cap for serving outside patients, also putting pressure of the doctor to not serve patients! What a system we’re designing!

This misguided position would pit doctors against patients, increase the number of temporarily unattached patients, increase the number of chronically unattached patients, and provide fewer opportunities for patients to gain access to medical care.

Finally, there is the fallacy that by forcing doctors to de-roster “frequent flyer” outside users, the MOH will save thousands of dollars on fees. No, they won’t. Take the example of a patient rostered to Doctor A but also seeing Doctor B, who provides him/her with their methadone. It would not be unusual for this patient to cost the system several thousands of dollars, just on the frequent visits to the methadone clinic. If Doctor A decides to cut his losses and de-roster (yes, the MOH wants you to de-roster them) this patient, how much will the MOH save? About $140/year, NOT the thousands that are being accumulated by the methadone clinic. The savings gained by de-rostering frequent flyers are limited to the fees paid to the rostering doctor, not the fees paid to the cause of the frequent flying. You can read more on the red-herring that outside use has become.

At the end of the day we need to fight for the right of patients to choose where they

obtain their care. We cannot be dragged into a fight with our patients. This cannot pass in any form. Patients have the right to choose where they get their care and have the right to change their mind; this is a democracy. We need to stop looking at countries that purport to be democratic in the delivery of health care, but in reality operate two-tier systems, such as in the UK; one for the wealthy and one for the masses. That's not who we are and what we want to be.

We are not some province in some third world country run by a despot, oh. Wait. Maybe we are.

H. **INCLUSION OF EMERGENCY DEPARTMENT USAGE IN OUTSIDE USE (FHO & FHN)**
**MOH Position:** The cost of any non-emergency hospital ED visit will be paid for by the MRP of the offending patient, if done during the weekdays.

Same concerns as outlined in comments in section G, above. In addition, hospitals are not motivated to triage and move these cases elsewhere. They see EDs as lucrative parts of their business and non-emergency cases are even better because they take fewer resources and less time. Making the family doctor financially responsible for this activity does not seem fair.

However, I understand there are physicians who would advise patient to seek services at EDs rather than at a walk-in so that outside use can be minimized. As much as this is repugnant I cannot believe it is done by any more than a minority of physicians, and in some cases there might be a valid reason for doing so, though I cannot come up with one. There is no need to punish all family doctors for the irresponsible actions of, I believe, of a few.

In my own experience and analysis of ED visits there were two clusters that stood out, 1. Recent refugees who saw the ED simply as an extension of the doctor's office, and 2. Non-compliant diabetics and those suffering from opioid use disorder. Although neither would be flagged as EDBMEs my point is that often ED visits are unrelated to a physician's availability.

Better still, why not mandate that all hospital EDs have access to a walk-in clinic in the hospital that operates daily and all non-emergency are diverted to that clinic by ED staff. I would have no issue that these monies be recouped from the MRP as long as the MRP is provided with an immediate notification through HRM, of the EDBME visit so that they can manage their patient roster more efficiently. In this manner, physicians who are

irresponsible in how they advise their patients will pay for the services and the physicians who are trying to work with the system can avoid large hits to their outside use.

**I. QUALITY IMPROVEMENT PLANS**

**MOH Position:** All physicians, regardless of model, will have to participate in QI

We don't have any major issue with this position. However, the MOH must acknowledge that the models that are presently involved in QI projects have significant budgets/personnel to help them design and bring the projects to fruition. Similar budgets/personnel would have to be provided to all new models expected to participate, including budgets for salary, benefits, space and equipment for any new staffing that need to be hired or shared.

**J. ADD A888A, G590A, and A002A to the basket of included codes**

**MOH Position:** Just the beginning of a longer-term plan to eliminate out-of-basket codes

**A888A –** Unfortunate that the MOH feels that holidays and weekends, when many families get to spend time together, are to be treated as any other day. Society can choose to make up any laws or conventions they like. In the case of weekends and holidays, they have been designated as being different; it was not long ago that retail stores could not open on Sundays, by law. But aside from retailers, who lobbied to be able to open every day, and, obviously for men/women of the cloth on the Christian holy day Sunday, most other segments of Canadian society do not work on weekends, and when they do, they are compensated for it. Doctors would accept this if all of society was being asked to do the same, and they aren't simply being unfairly treated. Would the Government agree to open up government offices (such as Service Ontario) and ask the employees to work for regular pay? What about schools? Ministry of Transportation offices? Etc.

Doctors are notoriously generous people and like to help. However, if it is mandated AND they are the only one being singled out, it will become a bone of contention. If MOH wants doctors to work weekends and holidays then I suggest they to use a carrot not a stick and negotiate a reasonable accommodation.

In my opinion, A888A is reasonable compensation for working on weekends/holidays.

**G590A –** Again, doctors can't be singled out for non payment. In this case, MOH pays pharmacies $7.00 to give a flu shot, Public Health agencies set up expensive flu shot

clinics (the cost of a flu shot can be calculated from these clinics), but doctors have to do it for less than $0.75. I don't think so.

**A002A –** The last agreement had A002A out of the basket. If the extensive 18 month well-baby review is still medically relevant, then there is no reason to move the review of this important medical milestone out of the basket.

**K. Eliminate Cumulative Preventative Care Bonus**

If these are still medically relevant, then there is no justification to not compensate doctors for the extra effort (staff, time) needed in getting this work done. The 2017 Commonwealth Fund[iv] concluded that Canada ranked 1st overall (out of 11 countries in the study) in nine Preventative Care indicators (see Appendix 2A: Preventative Care, pg. 18), so, as a country, our system works. You can access the report here. However, the Kiran *et al.* (2014) study concluded that incentives given to Ontario physicians improved colorectal screening but not breast or cervical screening.

A closer look at the data and the methodology, I am not totally convinced of their conclusions for several reasons; 1. The study was done after only a few years of implementing bonuses; it would have been useful to see what has happened since. 2. When using segmented linear regression, a pivot point or threshold point (the point at which the linear regression changes direction) is established. In this study for three cancer (colorectal, breast, cervical) the same pivot point (date at which changes occurred) was used for all three cancer screening rates, but whereas the data suggest that it was appropriate for the colorectal cancer screening (which improved with incentives) it does not look like it was an appropriate pivot point for the breast and cervical screening rates. Of course, I'm no statistician, so I could be wrong. 3. The study also showed, unintentionally, that Ontario Family Physicians are highly self-motivated, which may have been a confounding variable in this study. Basically, once physicians joined group practices with capitation, the screening rates increased by some 40% compared to their FFS counterparts – BEFORE any bonuses were being offered! In effect, "natural" annual increase in screening rates may have been due, in part, to physicians joining capitation models. That bonuses failed to boost the rates still higher may speak more to the self-motivation of Family Doctors who did the grunt work on prevention than to the failure of incentives. Financial incentives work, just ask an HR executive. 4. The study assumed that screening rates had to increase significantly to declare success of incentives. However, success can also be proclaimed if the incentive slowed down or reversed a deterioration of screening rates. There is some evidence that it may have

been the case for breast screening.

Finally, it should be noted that taking something away will never sit well with the recipient and there is the real possibility that if incentives are removed or changed significantly, it may cause a decline in screening.

**L. Discounts Applied to Services Billed Outside of Enrolling Group**

**MOH Position:** This is a two-pronged initiative, a) Penalize walk-in clinics, b) limit choices for patients.

I'm not sure I understand why the government would see the level of care given at walk-ins different than given to rostered patients for the same code. Maybe I am not aware of data that the MOH has. Certainly, I have seen MDs cherry pick patients they choose to see if they are working in a "walk-in" clinic or "walk-in" shift. But this is done more by the triage staff than the MD; a mutually-beneficial arrangement between MD and clinic owner. If this is an issue, the worst offenders are easily identifiable – can any MD really do proper medicine seeing more than 70, 80, 100 patients per day?

At any rate, physicians should not be penalized because patients make choices; it's undemocratic. And patients should never be forced, as in the UK and US, to belong to a particular doctor group, without choice. In Canada we like choice and sometimes we act on that, often for good, personal reasons.

Penalizing doctors who see patients who are not theirs, under these proposed changes will pit MDs with their ex-patients; patients who have been de-rostered because MDs were reducing the amount of outside use clawbacks that their practice would have to pay back. These newly-de-rostered patients will still view their primary MD as their MRP, not knowing they were, rightly, de-rostered for visiting another clinic. Now the MD must inform them that they would no longer be seen because they are not rostered and the compensation for a visit, which was ridiculously low, is even lower.

A bad idea all around. Don't penalize everyone and create more problems, identify the issue then fix it.

[i] Marchildon, GP and Hutchinson, B. 2016. Primary Care in Ontario, Canada: New proposals after 15 years of reform. Health Policy. 120 (2016) 732-738.

[ii] Kiran T, Wilton AS, Moineddin R, Paszat L, and Glazier RH. 2014. Effect of Payment Incentives on Cancer Screening in Ontario Primary Care. Annals of Family Medicine 12: 317-323.

[iii] Schneider E, Sarnak D, Squires D, Shah A, Doty M. Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care. New York, NY: The Commonwealth Fund; 2017 https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and

[iv] Schneider E, Sarnak D, Squires D, Shah A, Doty M. Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care. New York, NY: The Commonwealth Fund; 2017 https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and