FOR THE RECORD

Driving health care costs in Ontario

Payments to Ontario physicians more than doubled to $8 billion between 1992 and 2009 and now consume about 20 cents of every health care dollar spent in the province, according to a report from the Institute for Clinical Evaluative Sciences.

"Although overall physician supply rose in line with population growth, it varied substantially among specialties. The rise in physician payments since the turn of the century was considerably greater than the overall growth in physician numbers and has been growing significantly above the average rate of inflation since 2004/05," concludes the report, *Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources 1992/93 to 2009/10* (www.ices.on.ca/file/ICES_PhysiciansReport_2012.pdf).

The report notes that policies that affected payments to physicians between fiscal 1992/93 and 2009/10 included the four years in which the province imposed a global ceiling on payments to physicians; restrictions on the number of new billing numbers allowed between 1993 and 1997; penalties on physicians who set up their shingles in "over-serviced" areas between 1997 and 1999; targeted funding to reduce wait times for cancer surgery, cardiac procedures, cataract surgery, hip and knee replacement, and magnetic resonance imaging and computed tomography scans; and the move toward paying physicians through capitation, rather than on a fee-for-service basis.

Such policies have reversed a decline in the number of general practitioners/family physicians in the province, while benefiting some specialties more than others, the report states. "Efforts to reduce wait times in a fee-for-service environment have disproportionately benefited key surgical, medical procedural and diagnostic specialties. These groups have also gained financially from demographic changes, technological advances and increased health system capacity (i.e., increased hospital funding) that have enabled larger numbers of services to be provided by certain specialists in recent years."

The $8 billion spent on physicians in 2009 "has resulted in more practising physicians and an increase in services, particularly in areas targeted by certain policies. Alternative payment plans have supported certain government priorities and policy directions, particularly in general/family practice and the non-procedural medical specialties. This report cannot answer whether increased investment has led to better patient outcomes or improved functioning of the health care system. To our knowledge, no such impact analysis has been undertaken."

The factors combined to raise the mean payment per physician in Ontario to $334 700 in 2009/10 from $194 500 in 1993/94, while the median rose to $283 000 from $170 000. The annual payment increase was not evenly distributed through that time period but was always above the inflation rate. "Between 2005/06 and 2009/10, payments to physicians increased by 9.9% annually, compared with an average annual rate of inflation of less than 2% during the same period." The overall number of physicians in the province increased to 25 019 from 20 208 over the same time period. The number of family physicians rose to 10 799 from 10 207, while payments to those family physicians rose to $3.1 billion from roughly $1.6 billion.

The mean payment to family physicians rose to $300 100 in 2009/10 from $166 200 in 1993/94, an increase of 81%.

By specialty group, the highest paid in 2009/10 were (mean — % increase over 1993/94): diagnostic radiology ($606 700 — 55%); ophthalmology ($604 600 — 103%); nephrology; ($557 200 — 97%); nuclear medicine ($529 000 — 4%); vascular surgery ($545 000 — 77%); gastroenterology ($534 400 — 74%); cardiology ($531 000 — 75%); cardiac and thoracic surgery ($525 400 — 64%); neurosurgery ($450 300 — 95%); obstetrics/gynecology ($446 100 — 63%); otalargyngology ($436 400 — 56%); urology ($433 900 — 42%); radiation oncology ($432 400 — 307%); orthopedic surgery ($412 900 — 56%); general surgery ($410 500 — 77%); anesthesiology ($395 000 — 109%); dermatology ($383 400 — 34%); clinical immunology ($374 400 — 63%); respirology ($349 300 — 38%); plastic surgery ($348 500 — 33%); medical oncology ($330 600 — 145%); rheumatology ($299 200 — 52%); hematology ($291 500 — 101%); endocrinology ($275 600 — 48%); neurology ($271 900 — 36%); internal medicine ($271 500 — 67%); geriatric medicine ($264 100 — 192%); pediatrics ($261 300 — 38%); physical medicine and rehabilitation ($251 000 — 65%); emergency department physicians ($235 000 — 122%); and psychiatry ($193 000 — 27%).

The figures are gross payments and do not account for practice costs, which are typically held to be in the neighbourhood of 30%. — Wayne Kondro, *CMAJ*

US unveils regulations on health insurance disclosure

In hopes of reducing consumer and employer confusion about insurance lingo and health coverage options, United States President Barack Obama has proposed that private insurance companies and group health plans be compelled to provide "consumer friendly," concise and easy-to-understand information about their plans.

"All consumers, for the first time,

will really be able to clearly comprehend the sometimes confusing language insurance plans often use in marketing," Kathleen Sebelius, secretary of the Department of Health and Human Services, stated in a press release (www.hhs.gov/news/press/2012pres/02/20120209a.html). "This will give them a new edge in deciding which plan will best suit their needs and those of their families or employees."

At the core of the regulations, which take effect Sept. 23, is a requirement that health insurance firms provide potential buyers and current policy holders with clear, specific details about the coverage, limitations and costs of an offered plan.

The first page of the summary, presented in question-and-answer format, identifies specifics such as the level of deductibles, annual payment ceilings; or restrictions on the providers from whom health care can be sought (http://cciio.cms.gov/resources/files/Files2/02102012/blank-sbc-template-finalpdf.pdf).

On the following pages, the firm must identify any specific limitations on their coverage with respect to pharmaceuticals or such procedures as diagnostic tests, or with regard to health care providers, identifying clearly whether the consumer must shoulder a greater burden of costs from their own wallets if they choose to obtain their health care from a provider who isn't affiliated with the insurance company.

The firm must also indicate clearly to the consumer the financial extent to which their plans cover specific procedures (and deductibles therein) such as urgent care; emergency transportation; the services of physicians and surgeons; mental health therapy; substance abuse therapy; prenatal and postnatal care; dental care; rehabilitation services; glasses, etc..

The new regulations will also compel insurance companies to provide consumers, upon request, with a uniform glossary of terms commonly used when talking about health coverage, such as "balance billing" and "co-payment" (http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf).

The Obama administration contended the new requirements will make it easier for consumers to compare coverage options and understand what is and is not covered.

Insurers must also provide potential new customers with the user-friendly summaries of benefits and coverage prior to and upon application, while also informing renewing policy holders in a similar fashion.

The new regulations also require insurers to notify coverage holders of important changes to policy at least 60 days before the changes take effect. Roughly 150 million Americans are covered by private insurance. The most recent projections indicate that 81 million Americans do not have insurance coverage of any form. — Michael Monette, Ottawa, Ont.

Leaping into the health reform abyss

Reaction to the Commission on the Reform of Ontario's Public Services call for an overhaul of the province's health care system ranged from the muted to the miffed in the aftermath of the report's release.

Ontario's doctors, perhaps the primary target of the commission's recommendations (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4130) took issue with their characterization as being the nation's highest-paid physicians, while Ontario's hospitals lauded change.

Perhaps the bulk of the approbation was reserved for the commission's subtle, or perhaps not-so-subtle, recommendations that would nudge the province's health care system toward a greater measure of privatization, including one that stated that medical services "could be provided by private, for-profit entities, but operated within the public payer system. Government would continue to determine what services are offered and set the fees paid by OHIP [Ontario Health Insurance Plan]. The patient experience would, however, remain the same: upon presentation of a health card, the government will pay for the services rendered" (www.fin.gov.on.ca/en/reformcommission/chapters/ch5.html).

That's "chapter one" of a move to privatize the province's health care system, charged Michael Hurley, president of the Ontario Council of Hospital Unions, in a press release (www.ochu.on.ca/healthcare_news_releases.html). "By unbundling medical procedures currently available through public hospitals into a patchwork of private clinics and pushing patients into a home care system where 10,000 Ontarians are already waiting for supports, the Liberals are setting the stage for health care privatization chapter two down the road."

The Ontario Medical Association noted that physicians had a different perspective than economists, such as Don Drummond, who chaired the commission. "Economists look at things very differently than doctors do. As doctors, we will focus on patients, improving their health and well-being and ensuring they have access to the right care when they're sick. It will be important to strike the appropriate balance between finding efficiencies and protecting patient care."

While pleased about calls for an expansion of family health teams, more physician engagement in Local Health Integration Networks, more integration of electronic health records and the performance of more procedures outside hospitals, the association levelled broadsides at the call for a wage freeze on the grounds that the province's physicians were already generously compensated.

"The average gross payment for a family doctor in Ontario ranks 8th out of 10 provinces and is below the national average," Dr. Stewart Kennedy, the association's president, argued in a written statement provided to *CMAJ*.

Ontario Hospital Association Interim President and CEO Mark Rochon applauded the call for systemic reform, stating that "moving forward to address the province's financial challenges requires significant change" (www.oha.com/News/MediaCentre/Pages/Ontario%e2%80%99sHospitalsWelcomeDrummondReport.aspx).

But others trained their guns squarely on what they perceived as a breach of the Commission's mandate. The government had stipulated when it created the commission that it "will not make recommendations that would increase taxes

or lead to the privatization of health care or education" (www.fin.gov.on.ca/en/budget/ontariobudgets/2011/ch1b.html#c1_secB_sizeReduction).

The call for more private delivery of services was unwarranted, argued David McNeil, president of the Registered Nurses' Association of Ontario in a press release (www.rnao.org/Page.asp?PageID=924&ContentID=3660). "The Drummond Commission overstepped its mandate by making policy recommendations that steer the province to health care privatization," stated McNeil. "This market approach to health care goes against the research that shows care provided in not-for-profit health-care settings delivers better health outcomes for less money."

"Taxpayer dollars must be retained for front-line care, not for profit corporations," concurred Linda Haslam-Stroud, president of the Ontario Nurses Association (www.ona.org/news_details/ontario_nurses_say_health_care_changes_must_benefit_patients.html).

Hurley was no less un equivocal. "It's hard to imagine why our health minister thinks dialysis clinics and other procedures should be done in mobile trailers and shopping malls. Often patients have complex conditions that require a full range of specialized supports which are now available to them in our public hospitals. That will change drastically under this private clinic model," he stated.

Others were concerned about the distribution of resources between primary, secondary, long-term and home care.

"The Health Minister has disguised radical plans for cutbacks by calling them 'trade-offs' and 'reforms.' But if you look at the government's plans closely you can see that the numbers just don't add up. The bottom line is that they are planning to cut hospital services without providing enough money to support the existing patients languishing on wait lists for nursing homes and home care. There is simply no capacity to cut more hospital beds and download more patients," Sue Hotte, a retiree and board member of the Ontario Health Coalition, stated in a press release (www.web.net/ohc/mediareleasedrummond021012.pdf)

Coalition Director Natalie Mehra added that "funding for home care is already declining as a share of health spending. There is already less money available per home care client, meaning that care is more severely rationed and seniors are forced to pay user fees for needed services. This will just make it worse." — Lauren Vogel, *CMAJ*

More roadblocks on the electronic health highway

Models of care based on generating profit through volume and a reluctance to share information are among the major obstacles in achieving the promise of electronic medical records to improve the health of Americans, improve care and reduce health care costs, according to a nonprofit tank founded by former United States senators.

Collaborative and integrated health care delivered by multidisciplinary teams with access to electronic health records "will not become the norm without transforming the nation's primarily volume-based payment model to one that promotes higher quality, more cost-effective care," the Bipartisan Policy Center Task Force on Delivery System Reform and Health IT [information technology] states in a report, *Transforming Health Care: The Role of Health IT* (www.bipartisanpolicy.org/library/report/transforming-health-care-role-health-it).

Along with those "misaligned incentives," the task force, cochaired by former senators Dr. Bill Frist (Republican–Tennessee and heir to the Hospital Corporation of America, one of the US' largest for-profit hospital chains) and Tom Daschle (Democrat–South Dakota), identified an "extremely low" level of health information sharing as a barrier to "co-ordinated, accountable and patient-centered models of care."

Other obstacles included a "limited level of consumer engagement using electronic tools;" low levels of electronic health records "adoption and Meaningful Use among physicians, hospitals and other provider organizations;" and a lack of public trust that the privacy and security of health records will be maintained.

"Health care organizations are faced with numerous requirements associated not only with health IT, but also with delivery system and payment reforms, health care coverage and access challenges, administrative improvements, and program integrity brought about by the Patient Protection and Affordable Care Act" and other government programs.

To redress the six identified obstacles, the task force recommended that:

- Incentives and payments to federal, state and private sector purchasers and health plans be realigned with the new models of health delivery.
- The second stage of meaningful use regulations (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-3361), "along with related standards and certification criteria, should support and promote both the transmission of and access to standards-based data that reside across the multiple settings in which care and services are delivered. The federal government should collaborate with the private sector to develop a long-term strategy and plan to support the data needs associated with delivering care, empowering patients and improving population health. This plan, to be implemented within a policy framework, should be based on health and health care priorities. It should include the data content, transport, vocabulary and terminology standards needed for the exchange of health information across settings and a timeline for their evaluation and adoption." As well, a "national strategy for improving rates of accuracy in matching patients to their health information" should be developed.
- Consumer use of electronic tools should be promoted through new training and educational programs. "Tools that support the easy import and export of health information into and from consumer-facing applications should be developed and made widely available."
- Best practices for meaningful use of electronic health records, "including those related to clinical quality measurement, clinical decision support, computerized physician order entry, and public health surveillance

reporting" should be identified and disseminated. The private sector should develop and implement "training and implementation assistance programs, with a particular focus on small physician practices and community hospitals and clinics that deliver care to rural and underserved communities."

- The federal and state governments should issue "comprehensive and clear guidance" on privacy and security laws covering personal health information to alleviate patient privacy concerns.
- Government accountability measures and standards of care should be synchronized so that providers can focus on delivering care rather than meeting fuzzy or conflicting standards, while "public and private sector leaders should collaborate on the development of a common set of principles, policies, and standards related to the use of electronic data for population health purposes, including those related to measurement and improvement of outcomes, medical product safety, public health, and research." — Tomek Sysak, Ottawa, Ont.

CMAJ 2012. DOI:10.1503/cmaj.109-4137