3. Financial arrangements

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Key messages for citizens

- Public spending (i.e., government spending) on healthcare in Ontario is mostly financed through taxes, while private spending is mostly financed through direct out-of-pocket payments and premiums paid to private insurance plans.
- Many physicians are paid a set fee for each service they provide, but up to one third of all income received by physicians in Ontario is now paid to them in other ways (particularly in primary care). Other health professionals such as nurses are typically paid through salaries.
- While Ontarians are covered publicly for a wide range of necessary health products and services across all sectors, a number must be paid for out-of-pocket or through a private insurance plan (e.g., prescription drugs and dental services), which may result in citizens choosing not to access products and services that are not covered publicly.

Key messages for health professionals

- The largest portion of public revenues are allocated to Local Health Integration Networks to fund hospitals, home and community care agencies, and other organizations (in the case of hospitals through a combination of global budgets, the Health-Based Allocation Model and Quality-Based Procedures). The second-largest portion is allocated to the Ontario Health Insurance Plan, to pay for medically necessary services provided by physicians.
- Billing a set fee for each service is how most income is paid to Ontario's physicians, but other approaches are increasingly being used in primary care (e.g., payment for each enrolled patient in interprofessional models) and in academic hospital-based specialty care (e.g., payments to cover clinical research and teaching responsibilities). Non-physician health professionals, including most nurses, receive their income through salary arrangements.
- Medically necessary hospital-based and physician-provided services are fully covered for Ontarians, while public coverage of other products and services may depend on whether an individual is eligible for a public program (e.g., for prescription drugs) or a health professional prescribes or orders it (e.g., laboratory tests).

Key messages for policymakers

- An increasing proportion of total health spending in Ontario (32%) is financed privately through out-of-pocket payments or premiums paid to private insurance plans as the needs of Ontarians evolve beyond hospital-based and physician-provided services.
- Allocations of public revenues to Local Health Integration Networks and the Ontario Health Insurance Plan are the two largest government expenditures on the health system, and the ways this money is used to fund organizations and remunerate health professionals are periodically adjusted to align with health-system priorities (e.g., supporting interprofessional team-based primary care).
- Decisions about the products and services, populations and costs that are covered publicly may create disincentives for accessing care that is not covered.

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In this second of four chapters focused on the building blocks of the health system, we explore financial arrangements, with a particular emphasis on how money flows through the system. When thinking about money within the context of Ontario's health system, many readers may default to thinking about the total amount spent on healthcare in Ontario (i.e., expenditures). This makes sense given the substantial sums involved, and given that total expenditures (both public and private) in Ontario increased by 61%, from $41 billion in 2000 to almost $66 billion in 2013, and the total amount spent per person increased by 39%, from roughly $3,500 per person in 2000 to approximately $4,900 per person in 2013 (all in 2002 dollars).(1-9)

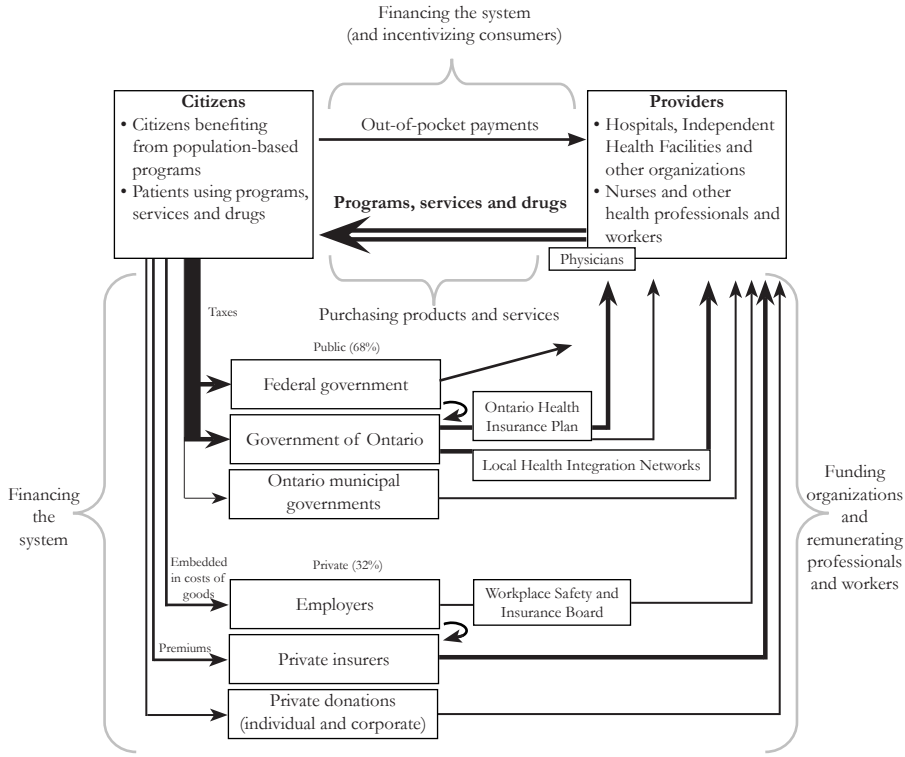
While these numbers often attract attention in the media, they do not illuminate how money flows through the health system in Ontario, which is a key influence on how the system functions. Five inter-related categories of financial arrangements can be considered in order to provide a more comprehensive account of financial flows in the province: 1) financing the system (i.e., raising revenue); 2) funding organizations; 3) remunerating providers (both regulated health professionals and unregulated health workers); 4) purchasing products and services; and 5) incentivizing consumers.

This chapter is organized into sections that focus on each of these categories, which are depicted in Figure 3.1 as elements in the process of financial flows in the health system. While we separate the process into discrete elements to help explain the process in a clear way, in reality they are neither completely separate, nor sequential. The days of a simple contractual relationship between a service recipient (e.g., a patient paying for the care they want or need) and a service provider (e.g., a health professional providing that care) are long gone in most parts of most health systems around the world.(10) Today a variety of 'third parties' (e.g., government, private insurers, and workers' compensations boards) are involved in a web of relationships with providers that is often not visible to the service recipient (and sometimes not even to the provider).

The top left of Figure 3.1, the first element in the sequential representation of financial flows in Ontario's health system, depicts the primary source of revenue raised to pay for healthcare in the province: citizens. As we noted in the preface, we mean citizen in the broad sense of the term, not just those who hold Canadian citizenship and reside in Ontario (and we include permanent residents and refugees). Following the diagram in a counter-clockwise fashion, it shows that financial resources are collected from citizens through taxes and other means (e.g., insurance premiums) then move to government, private insurers and others (e.g., employers), where revenues are pooled. In this chapter, we refer to this process as 'financing the system.'

The second and third elements in the flow of financial resources through the health system in Ontario are depicted on the right side of Figure 3.1, and concern how pooled revenues become the money spent on care. The second element relates to how the revenues raised are allocated to the organizations responsible for providing programs, services and drugs to the citizens who need them, which we refer to as 'funding organizations' in this chapter. The third element relates to how the revenues raised are used to pay the individuals providing programs, services and drugs to the citizens who need them, which we refer to as 'remunerating providers' in this chapter. Some individuals may be remunerated directly by governments, private insurers, and others (e.g., physicians), while others may be remunerated by the organizations that are funded by governments, private insurers and others.

Figure 3.1: Financial arrangements, with a particular focus on the flow of money through the health system



Sources: Adapted from: 65

The fourth element of health system financial flows is represented by the double arrow line at the top of Figure 3.1, and concerns the process through which the money spent on care translates into the programs, services and drugs used by the citizens of Ontario within the boundaries of a defined 'basket of services.' This is an ongoing process which we refer to in this chapter as 'purchasing products and services,' and relates to how decisions are made about the types of care paid for with public dollars (and therefore how much of the cost is covered for citizens). As Chapter 1 of this book already explained, at the most basic level, the health system in Ontario is defined by a 'core bargain' in which Ontarians have first-dollar coverage (i.e., 100% coverage with no deductible or cost-sharing) for all medically necessary hospital-based and physician-provided services – although as this chapter will highlight, there are many more nuances in the 'basket' of publicly funded programs, services and drugs. Perhaps more so with this element than any other discussed in this chapter, it is important to

acknowledge that the sequence in which we have chosen to discuss the nature of purchasing products and services is to promote clarity in terms of understanding the 'big picture' of financial flows, and not necessarily the stage in the process where decisions are made. For example, in many instances the lists of covered programs, services and drugs are defined before organizations are funded and professionals are paid to deliver them to citizens.

The final element in the process, which is also represented by the top of Figure 3.1, is not really an element of a process in the traditional sense of the term. Specifically, what we refer to as 'incentivizing consumers' in this chapter relates to the consequences of the options adopted to finance the system. In discussing this, we focus on the ways in which approaches to healthcare financing, such as out-of-pocket payments, are used to encourage individual patients (or in this context, healthcare 'consumers') to interact with the health system in specific ways.

We now turn to detailed discussions of each of these categories, but suggest that readers periodically return to Figure 3.1 as a way to ensure the 'big picture' related to financial flows is kept in mind. For those interested in finding and using the best available synthesized research evidence about health-system financial arrangements, first understanding each of the categories below will be of great assistance. It is these categories that are used to index the full scope of systematic reviews, economic evaluations and policy documents on this topic in Health Systems Evidence (www.healthsystemsevidence.org), which is the world's most comprehensive free access point for research evidence about health-system arrangements, including financial arrangements.

Financing the system

The first element in the process of financial flows through any health system concerns where the money actually comes from to pay for care (represented in the top left corner of Figure 3.1). In any given health system, a number of options – both public and private – exist for financing the system, including raising revenue through:

1) taxation (general or earmarked taxation of individuals or corporations, with the latter meaning taxation that is designated specifically for

healthcare);
2) social health insurance (groupings of citizens, defined usually by occupation, make contributions, at least in part through income deductions);
3) community-based health insurance schemes (community-defined groups of citizens, such as those living in a particular geographic area, make contributions to insure community members against illness or injury);
4) community loan funds (community-defined groups of individuals establish a pool of funds that other community members can draw on for urgent healthcare needs);
5) private insurance (individuals, or their employers, make contributions to private insurers through premiums);
6) health savings accounts (individuals or employers make contributions to individual savings accounts earmarked for healthcare expenditures only);
7) user fees (out-of-pocket fees charged directly to patients to pay for products and services at the point of service delivery); and
8) fundraising (raising funds directly to support the construction or upgrading of infrastructure like buildings, the purchase of infrastructure like new technology, and the operating costs of healthcare clinics or organizations).

In general, most health systems are characterized by a mix of two or more of these options, and in Ontario the same is true. Specifically, as Figure 3.1 shows, the health system relies mostly on option 1 (both general and some earmarked) and to a lesser extent option 5 (private insurance premiums, many of which are part of employee benefits). However, there are some instances in which option 7 (e.g., paying out-of-pocket for the full price of uninsured products and services, user fees such as patient co-payments for prescription drugs or payments for home and community care above an assessed maximum) and option 8 (e.g., fundraising to pay for the construction of or upgrades to private not-for-profit hospitals) are also used as a mechanism to finance the health system.

Revenues

Details about the breakdown of total health expenditures in Ontario by both public and private sources have already been provided in Chapter 1 (e.g., see Figure 1.2, and Tables 1.4 and 1.5), but they are worth revisiting

here as they are very relevant to the mechanisms through which revenues are raised to pay for healthcare in Ontario.

The first important consideration relates to the sources of public revenues used to finance the health system in Ontario, which account for 68% of total health expenditures in the province (Figure 1.2). The majority of the public revenues spent on healthcare in Ontario are generated through provincial taxation, which accounts for nearly 80% of all public sources of revenue.(11) The main sources for these public revenues are personal income tax (which accounts for 37%), sales tax (26%), and corporate tax (14%), with the remainder coming from other sources of taxation such as the education component of property tax, employer health tax, gas and fuel taxes, and the Ontario health premium.(11) Transfers from the federal government to the province make up the remaining 20% of public revenue available for allocation to the health system, and of this, nearly 54% comes from the Canada Health Transfer (which is provided to provincial governments on the condition that the principles of the *Canada Health Act, 1984* are adhered to), 21% from the Canada Social Transfer, and the rest through other mechanisms.(11)

The second important consideration relates to the remaining 32% of health expenditures in Ontario, which are financed from two major sources of private revenues. The first source of private financing is direct out-of-pocket payments for products and services not covered by the government, which accounted for 80% of private revenues in Ontario in 2013. The second source is insurance premiums paid to cover products and services not paid for by government, which accounted for the remaining 20% of private revenues in Ontario.(12)

While the majority of the money raised to pay for hospitals comes from public sources, hospitals typically have affiliated foundations that are registered charities, and in many cases, significant proportions of their total annual revenues are generated from donations and grants (see the bottom of Figure 3.1). For example, University Health Network, which is comprised of several hospital sites in downtown Toronto, received 14% ($279 million) of its total revenues from donations and grants in 2015.(13) The private charitable donations made by individual philanthropists and corporate foundations are particularly noteworthy because they are often used to pay for the construction of, or upgrades to, buildings (and related

technology). For example, in 2014 the Rogers Foundation donated $130 million to University Health Network to establish the Ted Rogers Centre for Heart Research, while Michael G. DeGroote has donated more than $150 million since 2003 to the hospital-connected medical school that bears his name at McMaster University.(14; 15)

Expenditures

As previously mentioned, the substantial sums of money generated from the revenue sources outlined above are then spent on the health system, and the general trend over the last decade and a half has been towards increases in the amount spent. Total spending in 2002 dollars – both public and private – increased by 61% from $41 billion dollars in 2000 to nearly $66 billion dollars in 2013 (Table 3.1). Over this same time period, total per capita health spending in 2002 dollars increased from just over $3,500 per person to just under $4,900 per person, which is close to the Canadian average, although trends suggest the amounts spent per person in total are likely to remain constant, or decrease slightly (Figure 3.2).

Table 3.1: Total health expenditures, by public and private sources of finance[1]

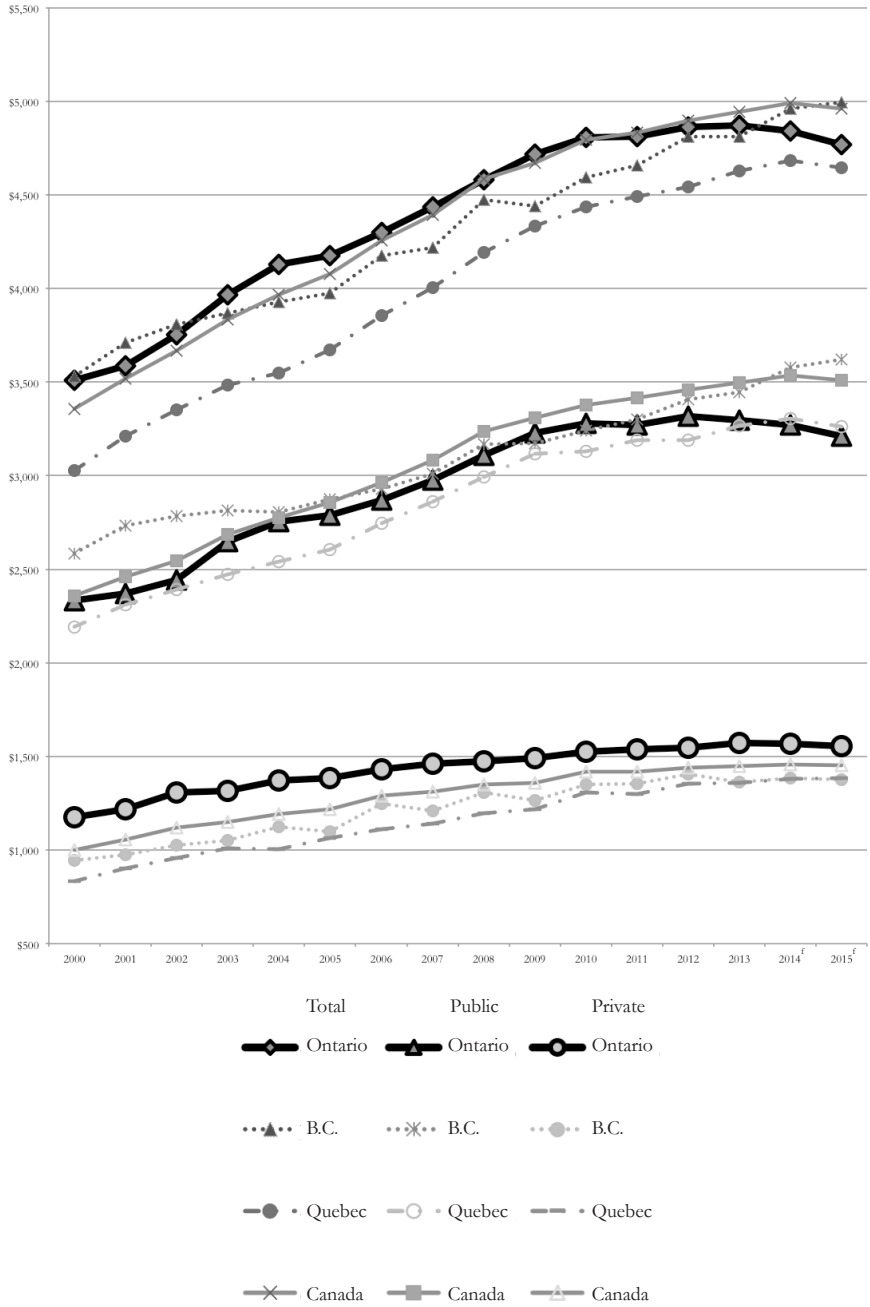
Category of health expenditure ($ millions)	Ontario			Canada
	2000	2010	2013	2013
Total spending	41,008	63,113	65,977	205,981
Total public sector spending	27,267	43,060	44,669	145,685
Provincial government	25,148	40,171	41,914	135,300
Federal direct	1,170	1,802	1,821	6,749
Municipal government	590	604	408	799
Social security (Workplace Safety and Insurance Board)	357	483	526	2,837
Total private sector spending	13,742	20,053	21,308	60,297

Sources: 2; 4; 5; 8; 68-70

Note:
[1] Inflation adjusted to 2002, according to Statistics Canada's Consumer Price Index (healthcare), CANSIM 326-0020: value x (CPI 2002/CPIi) = value (2002) where i = year

The trends outlined above for total expenditures on the health system in the province (i.e., public and private combined) are broadly similar to those observed for public expenditures on the health system. Ninety-four percent of public spending is done by the provincial government (which includes money received from federal-provincial transfers) and 4% by the federal government (through federal direct spending on programs, services

Figure 3.2: Per capita health expenditures, both overall and by public and private sources of finance, 2000 to 2015[1,2]



Sources: 3; 8; 66; 67

Notes:

[1] Inflation adjusted to 2002, according to Statistics Canada's Consumer Price Index (healthcare), CANSIM 326-0020: value x (CPI 2002/CPIi) = value (2002) where i = year

[2] Expenditures for 2014 and 2015 are forecasts. This is denoted by a superscript 'f' following the year indicated on the horizontal axis.

and drugs for First Nations communities, military personnel, etc.). The remainder comes from municipal governments and social security funds, the latter of which is made up of contributions to the Workplace Safety and Insurance Board (Table 3.1). The long-term trend has been an increase in total public expenditures in Ontario, with a 64% increase in total public spending in 2002 dollars – from just over $27 billion in 2000 to almost $45 billion in 2013 – and an increase in per capita public spending in 2002 dollars over the same time period from just over $2,300 per person to approximately $3,300 (Figure 3.2 and Table 3.1). However, over the shorter term (since 2011), the trend appears to be that per capita public expenditures are levelling off (Figure 3.2).

While total private spending is less than total public spending in absolute terms, private expenditures have increased in 2002 dollars by 55% between 2000 and 2013, from under $14 billion to over $21 billion (Table 3.1). Per capita private spending has increased in 2002 dollars from $1,176 in 2000 to $1,572 in 2013 in Ontario, which is higher than the Canadian average of $1,447 in 2013 (Figure 3.2). Private expenditures in part take the form of allocations from employers to private insurers, which then allocate funds to a wide variety of health organizations and health professionals in the province providing programs, services and drugs that are not covered publicly. In 2013, a total of $378 million in 2002 dollars was spent on health insurance premiums, of which approximately one quarter was used to pay (at least in part) for supplemental elements of hospital care, including private rooms (Table 3.2). Additionally, through out-of-pocket payments for programs, services and drugs (as well as other 'technologies'), individual Ontarians are directly responsible for 80% of private spending (see top of Figure 3.1). In 2013 over $1.5 billion in 2002 dollars in direct out-of-pocket payments were made by individuals (Table 3.2).

Finally, while not as easily measured or reported accurately with specific numbers, it is also important to consider tax revenues forgone because of the preferential tax treatment of select private health-related expenditures. Examples of these types of 'tax expenditures' include the exclusion of employer-provided health insurance from income, as well as the medical expense tax credit, the disability tax credit, and disability savings accounts.

Table 3.2: Private health expenditures, by type of product, service or insurance plan being paid for, 2010 and 2013[1]

Category of private health expenditures ($ millions)	Ontario		Canada
	2010	2013	2013
Private health expenditures[2]	1,579	1,919	2,479
Direct healthcare costs to household	1,297	1,541	1,733
Non-prescribed medicines, pharmaceutical products and healthcare supplies	349	523	484
Prescribed medicines and pharmaceutical products	338	273	452
Dental services	302	246	346
Eye-care goods and services	135	172	230
Healthcare services	174	166	221
Healthcare practitioners (excluding family physicians and specialists)	100	97	125
Hospital care, long-term care homes and other residential care facilities	39	32	39
Weight-control programs, smoking cessation programs and other medical services	23	21	30
Healthcare by family physicians and specialists	13	15	28
Health insurance premiums	281	378	746
Private health insurance plan premiums	217	285	528
Private healthcare plan premiums	122	177	355
Accident or disability insurance premiums	81	89	130
Dental plan premiums	14	20	43
Public hospital, medical and drug plan premiums	65	93	218

Sources: 8; 12

Notes:
[1] Inflation adjusted to 2002, according to Statistics Canada's Consumer Price Index (healthcare), CANSIM 326-0020: value x (CPI 2002/CPIi) = value (2002) where i = year
[2] Includes direct costs to household (out-of-pocket) net of the expenditures reimbursed, and health insurance premiums

Funding organizations

The second element in the process of financial flows through the health system in Ontario is the use of the revenues that are raised in order to fund organizations responsible for providing programs, services and drugs (represented by part of the right side of Figure 3.1). The most important aspect of how organizations are funded in Ontario's health system concerns the transfers from the Ministry of Health and Long-Term Care to the 14 Local Health Integration Networks (LHINs), which provide funding to independent organizations with (often high profile) boards of directors in their region (as opposed to the regional authorities in other provinces

that fund programs and services directly rather than through organizations with separate boards of directors) (Figure 3.1). This process involves many home and community care organizations, all hospitals, and many long-term care homes (although some homes receive funding directly from the ministry). Hospitals, it is worth noting, receive 3.5 times the amount of public funding received by other organizations combined (Table 3.3). Importantly, while finances flow through LHINs, these administrative organizations generally have little discretion as to how funds are allocated because the recipients and the amounts they receive are largely determined by procedures (e.g., licensing of long-term care homes) and formulae (e.g., Health-Based Allocation Model for hospitals) set by government.

Table 3.3: Public and private health expenditures, by type of organization or program being funded, 2013

Category of public and private health expenditure ($ millions)	Ontario[1]	Canada	Ontario[1]	Canada
	2013		% distribution	
Public				
Total	53,915	148,143		
Hospitals	19,379	56,487	36%	38%
Physicians	12,790	31,288	24%	21%
Other institutions	5,481	15,537	10%	11%
Drugs	4,655	12,044	9%	8%
Prescribed	—	12,044	—	8%
Non-prescribed	—	0	—	0
Public health	4,550	11,368	8%	8%
Other health spending	3,229	9,435	6%	6%
Health research	—	2,053	—	1%
Other	—	7,381	—	5%
Capital	2,477	7,446	5%	5%
Administration	828	2,680	2%	2%
Other professionals	526	1,859	1%	1%
Dental services	—	791	—	0.5%
Vision care services	—	360	—	0.2%
Other	—	709	—	0.5%
Private				
Total	25,719	61,314		
Drugs	8,594	21,353	33%	35%
Prescribed	—	16,261	—	27%
Non-prescribed	—	5,092	—	8%
Other professionals	7,350	18,915	29%	31%
Dental services	—	12,087	—	20%

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Category of public and private health expenditure ($ millions)	Ontario[1]	Canada	Ontario[1]	Canada
	2013		% distribution	
Private – continued				
Vision care services	—	3,637	—	6%
Other	—	3,191	—	5%
Hospitals	3,306	5,894	13%	10%
Other institutions	2,566	6,402	10%	10%
Other health spending	1,626	3,311	6%	5%
Health research	—	1,529	—	3%
Other	—	1,782	—	3%
Administration	1,387	3,661	5%	6%
Capital	791	1,383	3%	2%
Physicians	98	395	0.4%	0.6%
Public health	0	0	0	0

Sources: 71-78

Note:
[1] Data not available for the specific reference period are denoted by —.

LHINs account for slighly more than half (51%) of all spending by the ministry (Table 3.4). Budget allocations from the Ministry of Health and Long-Term Care to each LHIN to pay these organizations varies across the regions, with the Toronto Central LHIN (in downtown Toronto) receiving the largest transfer. At close to $3,500 spent per person in 2002 dollars, per capita allocations (calculated by dividing the operating expenses of each region by the population served) are also highest in this LHIN, which is likely due to the large number of people who travel to Toronto from other regions to receive specialty care. The lowest per capita allocations (under $1,000 spent per person) are to the LHINs bordering Toronto Central (Central and Central West), where their populations are also served by Toronto Central. Allocations are generally similar across all other LHINs.

Table 3.4: Public health expenditures by the Ministry of Health and Long-Term Care, by type of program being paid for, 2011-12

Program	2011-12 operating expenses
Local Health Integration Networks (LHINs) and related health service providers[1]	
Transfer payments to 14 LHINs:	23,700,133,616
Toronto Central	4,429,833,600
Hamilton Niagara Haldimand Brant	2,648,185,300
Champlain (Ottawa)	2,398,969,800
South West (London)	2,116,960,100

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Program	2011-12 operating expenses
Transfer payments to 14 LHINs – continued	
Central East	2,095,556,2000
Central	1,795,391,200
North East (Timmins)	1,363,231,600
Mississauga Halton	1,302,317,300
South East (Kingston)	1,061,416,400
Erie St. Clair (Windsor)	1,056,645,300
Waterloo Wellington	959,137,200
Central West	805,145,400
North Simcoe Muskoka	761,496,000
North West (Thunder Bay)	595,657,400
Ontario Health Insurance Plan	16,888,990,910
Health Insurance Transfer payments for care provided by:	
physicians and other healthcare providers	12,753,267,700
midwifery services	125,488,200
colorectal cancer screening	75,457,100
Independent Health Facilities	69,427,300
Northern Travel Program	52,581,600
teletriage services	41,763,400
Health Quality Ontario	36,193,100
disease-prevention strategy	34,469,200
quality health initiatives	22,304,400
underserviced area plan	21,713,500
Quality Management Program - laboratory services	4,598,900
Drug programs Transfer payments to:	
Ontario Public Drug Programs	3,600,623,500
Assistive devices programs Transfer payments to:	
Assistive Devices Program	336,970,900
Home Oxygen Program	89,291,500
Provincial programs and stewardship Emergency health services Stewardship Provincial programs transfer payments to:	3,109,228,575
community and priority services	2,402,799,700
Cancer Care Ontario	652,173,000
Canadian Blood Services	497,758,700
chronic disease management	100,975,200
healthy homes renovation tax credit	85,775,700

Continued on next page

Program	2011-12 operating expenses
Provincial programs transfer payments – continued	
Ontario Breast Screening Program	72,542,400
HIV/AIDS and hepatitis C programs	54,802,200
operation and related facilities	40,375,900
Health policy and research program Transfer payments to:	774,426,268
clinical education	890,683,600
Health System Research Fund	42,688,700
Public health program Transfer payments to:	679,112,170
local public health agencies	367,856,100
outbreaks and diseases	168,678,400
Public Health Ontario	150,965,200
infection control	19,900,400
tuberculosis prevention	8,013,900
sexually transmitted diseases control	3,425,200
public health associations	332,300
eHealth and information management program Transfer payments to:	523,970,420
eHealth Ontario	367,186,600
information technology programs	52,492,000
health-system information management	25,608,600
Health promotion Transfer payments to:	342,751,973
official local health agencies	367,856,100
Smoke-Free Ontario	44,942,400
prevent disease, injury and addiction	14,540,000
healthy communities fund	7,675,000
nutrition/healthy eating	6,384,500
local capacity and coordination	1,096,800
Ministry administration program Ministry administration	
Ontario Review Board, which oversees individuals who have been found by a court to be either unfit to stand trial or not criminally responsible due to a mental disorder	93,029,971
Information systems	82,823,033
Information technology systems	
Health cluster	
Total operating expense[2]	46,194,466,936

Sources: 79; 80

Notes:
[1] LHIN funding covers Community Care Access Centres (includes home care services), community support services, community mental health and addiction agencies, assisted living services in supportive housing, Community Health Centres, Aboriginal Health Access Centres, hospitals, and long-term care homes.
[2] Covers the ministry's total operating expense and capital including consolidation and other adjustments (not including assets)

As with the mix of options available to finance the health system, a number of options can be used by LHINs (and by government) to fund the range of healthcare organizations involved in the provision of programs and services in the health system, including:

1) fee-for-service funding (organizations receive a fixed fee for each service performed in their facilities);
2) capitation (organizations receive a fixed fee for each patient under their care);
3) global budgets (organizations receive a fixed budget to cover all necessary care for a given period of time);
4) case-mix funding (organizations receive pre-determined payments for particular types of diagnoses or services that are meant to cover the costs associated with an entire episode of care, regardless of the programs, services and drugs provided; and
5) targeted payments and/or penalties (organizations receive additional payments for taking a measurable action or achieving a predetermined performance target, or penalties for failure to do so).

Organizations may also be given an indicative (or shadow) budget to guide their decisions about the amount of money available to care for their patients, and the optimal allocation of that budget, however, this is not used to determine the actual funding they receive.

While a diverse and complicated mix of these funding options have been used in Ontario (many of which are referred to using names unique to the province), LHINs have mostly relied on a mix of global budgets (option 3) complemented by case-mix funding (option 4) and targeted payments (option 5). The amounts that hospitals receive are established through agreements between hospitals and LHINs, and specified in Hospital Service Accountability Agreements. A similar process is followed to establish what are referred to as Multi-Sector Service Accountability Agreements for Community Care Access Centres (CCACs), Community Health Centres, community mental health and addictions organizations, other home and community care agencies, and long-term care homes. Table 3.5 details the main mechanisms used to fund organizations by sector in Ontario, and we discuss each briefly in turn below.

Table 3.5: Organizational funding mechanisms in use

Type of organization	Funding mechanism
Home and community care	
Community Care Access Centres (CCACs)	• (Currently transitioning to) global budgets (30%) and a combination of Health-Based Allocation Model and Quality-Based Procedures (70%) allocated by Local Health Integration Networks (LHINs) • Additional one-time funding available for targeted activities (e.g., achieving five-day wait-time targets)
Organizations providing home and community care	• Global budgets allocated by LHINs to provide a basket of services in a geographic area over a number of years as specified in Multi-Sector Service Accountability Agreements • One-time payments from CCACs to organizations that are prequalified by the Ontario Association of Community Care Access Centres to provide services to eligible citizens
Community mental health and addiction organizations	• Global budgets allocated by LHINs • One-time payments for amendments to service plans and targeted activities
Primary care	
Family Health Teams	• Global budgets approved annually and allocated by the Ministry of Health and Long-Term Care • Mixed physician-remuneration strategies (e.g., blended capitation, blended salary and/or complement-based remuneration), which we return to in Table 3.7 • Direct payments for clinical support staff
Aboriginal Health Access Centres	• Global budget allocated by LHINs • One-time payments for additional agreements (e.g., Business Intelligence Reporting Tool) or approved amendments to service plans
Nurse Practitioner-led Clinics	• Global budgets allocated by the Ministry of Health and Long-Term Care • Additional billings made by consulting physicians for each service they provide
Community Health Centres	• Global budgets allocated by LHINs • One-time payments for additional agreements (e.g., Project Funding agreements) or approved amendments to service plans
Specialty care (with a focus on hospital funding)	
Private not-for-profit hospitals	• Global budgets, Health-Based Allocation Model, and Quality-Based Procedures allocated by LHINs • (While not formally part of hospital budgets) standard physician fees based on the Schedule of Benefits for Physician Services
Independent Health Facilities	• Facility fees based on the Schedule of Facility Fees for Independent Health Facilities • Standard physician fees based on the Schedule of Benefits for Physician Services
Out of Hospital Premises	• For medically necessary (insured) services, standard physician fees based on the Schedule of Benefits for Physician Services • For non-insured services, individual fees or block payments from patients typically based on Ontario Medical Association recommendations for uninsured services

Continued on next page

Type of organization	Funding mechanism
Long-term care	
Long-term care homes	• Per diem payments (an average rate per resident per day) for all residents, either alone or alongside a global budget, which can be allocated by LHINs or directly by government • Resident payments of standardized accommodation charges (with a subsidy from government for those who cannot afford them) • (While not formally part of long-term care home budgets) standard physician fees based on the Schedule of Benefits for Physician Services
Public health	
Public health units	• Program-based grants for mandatory programs split 75% from the Ministry of Health and Long-Term Care and 25% from municipal funds • Ad hoc funding from other government sources for non-mandatory programs

Sources: 81-99

Home and community care funding

As mentioned above, publicly covered home and community care is funded by the LHINs (Table 3.5). Funding is approached in a number of ways, mostly through allocations to CCACs that then establish contracts with organizations providing nursing, personal support and homemaking services. Allocations to CCACs have historically been made through global budgets, but this has changed recently (and the changes are covered in greater detail in Chapter 10). Specifically, the health system funding reform that began in 2012 will eventually ensure that funding to CCACs is derived from a combination of global budgets (30%) and a mix of funds allocated through the Health-Based Allocation Model (a form of global budget) and Quality-Based Procedures (a form of case-mix funding), which together will account for the remaining 70% of CCAC funding annually (Table 3.5).

Details about how the Health-Based Allocation Model is calculated are not publicly available for CCACs (or for hospitals, which are discussed below), although it is known that payments are based on a number of inputs that can be used to predict how many services will be needed each year and the costs of those services (e.g., historical service volumes, expected population growth, and healthcare access patterns in a specific region). Quality-Based Procedures are calculated based on the costs of all of the services required as part of an optimal clinical pathway for an episode of care (or for a discrete part of the clinical pathway).(16; 17)

For the fiscal year ending March 31, 2015, a total of $2.5 billion in funding

was received by CCACs (through LHINs) to provide home care services for 713,493 clients in the province, which means approximately $3,500 was spent on home care for each client receiving support.(18) This represents a 42% increase in funding (albeit with no correction for inflation), and a 22% increase in clients served, since 2009.(18) The government also announced plans to increase funding to the home and community care sector over three years (2015-16 to 2017-18) at 5% per year (approximately $750 million in additional funds).(18)

However, recent reform proposals first shared by the Ministry of Health and Long-Term Care in December 2015 and since described in the *Patients First Act, 2016* (also covered in greater detail in Chapter 10), involve the CCACs being eliminated and their current duties assumed by the LHINs. The scope of services that are funded, however, is unlikely to change.(19)

A number of other organizations fall within the home and community care sector, and these organizations are funded in different ways (Table 3.5). Organizations providing home and community care such as assisted living services in supportive housing, as well as community mental health and addictions organizations, are funded through global budgets, and all have access to additional targeted payments either for special projects or through amendments to their funding agreements.

Primary care funding

While the bulk of primary care is paid for through direct payments to physicians, which we cover in the next section on remunerating providers, recent changes in how primary care is organized in the province has resulted in the introduction of new organizational funding models (more details about these changes in primary care are covered in Chapter 6, which focuses on care in each sector). In particular, the establishment of physician-led Family Health Teams has created 184 primary-care organizations that are funded through a blend of annually approved global budgets, mixed physician-remuneration strategies (e.g., blended approaches that combine capitation payments for each enrolled patient, with set fees for each service provided), and direct payments for clinical support staff (Table 3.5). Nurse Practitioner-led Clinics, which are characterized by interprofessional team-based care with nurse practitioners as the 'most responsible' provider, are

also a relatively recent addition to the primary-care sector. These clinics are funded by the Ministry of Health and Long-Term Care through global budgets, with additional billings made by consulting physicians for each service they provide.(20)

Aboriginal Health Access Centres and Community Health Centres are two additional types of publicly funded organizations in Ontario's primary-care sector. Aboriginal Health Access Centres are Indigenous community-led primary healthcare organizations that provide traditional healing in combination with primary-care services to First Nations, Inuit and Métis communities in Ontario. These organizations are funded by the Ministry of Health and Long-Term Care through global budgets as part of the Aboriginal Health and Wellness Strategy, and also receive additional one-time targeted payments from LHINs for activities such as cultural competency training (e.g., Indigenous Cultural Safety Training provided by the South West LHIN). Community Health Centres deliver services targeted to specific communities, and focus primarily on ensuring access to comprehensive primary-care services for low-income Ontarians, street youth, homeless persons, the isolated elderly, newcomers, and those living in rural and remote communities. These organizations receive annual budgets from LHINs, which are specified in a Multi-Sector Service Accountability Agreement.

Specialty care (hospital) funding

Because payments made to hospitals constitute the bulk of funding in specialty care, we focus here on the mechanisms used to fund hospitals. As pointed out earlier in this chapter, hospitals are the organizations that receive the greatest share of public funding. As of 2013, the total amount spent on hospitals amounted to nearly $20 billion, or 36% of all public spending on healthcare in the province (Table 3.3). Hospital funding covers nearly all of the costs associated with the programs, services and drugs provided in hospitals, with the notable exception of physician billings (which are covered by the Ontario Health Insurance Plan, or OHIP). These sums also cover the cost of hospital administration, including the salaries of senior executives, which are partly tied to achieving performance-improvement targets.(21) While the majority of hospital funding comes from public sources, more than $3 billion in private expenditures were channelled to hospitals in 2013 (Table 3.3).

Increasingly, in order to make the most of these budget allocations, hospitals within a single geographical region (e.g., Toronto Central LHIN) are entering into agreements with shared-service organizations to achieve supply-chain and operational efficiencies.(22) An expert panel on the development and implementation of a province-wide supply-chain management strategy for the healthcare sector has been established to provide recommendations about how to achieve further efficiencies.(23)

Hospitals receive their public funding from LHINs through a combination of three mechanisms: 1) global budgets; 2) the Health-Based Allocation Model (a form of global budget); and 3) Quality-Based Procedures (a form of case-mix funding). Global budgets (lump sum payments to cover operating costs for an entire year) are used to allocate approximately 30% of hospital budgets. The Health-Based Allocation Model accounts for the allocation of approximately 40% of hospital budgets in the province (Table 3.5). As with CCACs, specific details of how this model is calculated for each hospital are not publicly available. As noted above, the approach tries to predict the volume and cost of services in the coming year by looking at historical service volumes, expected population growth, and healthcare access patterns in a specific region, as well as the size and teaching status of a hospital. The remainder of hospital budgets (30%) is funded through Quality-Based Procedures, which are described in relation to CCAC funding above, and apply to all or part of an episode of care, rather than a single service, again without including physician billings. Ten types of patient services are currently paid as Quality-Based Procedures in hospitals: hip replacement, knee replacement, treatment for chronic kidney disease, treatment for cataract, gastrointestinal endoscopy, chemotherapy/systemic treatment, non-cardiac vascular repairs, treatment for congestive heart failure, treatment for chronic obstructive pulmonary disease, and treatment for stroke.(24) Hospitals also supplement these public revenues with donations and grants, as well as revenue from parking, space rental (e.g., for coffee shops in hospital lobbies), and other sources.

Alternative approaches that link hospital care to other sectors such as home and community care by funding an entire episode of care – including all services provided across all settings within each episode – are also being piloted. For example, since 2012 St. Joseph's Health Care Hamilton has been experimenting with 'bundled care,' another form of case-mix funding, in which hospital and home-care dollars are combined and 'tied' to

individual patients (particularly those undergoing lung-cancer surgery or hip/knee replacements, and those with chronic obstructive pulmonary disease). In this model, staff working in hospitals are linked with their counterparts in the community, many of whom are responsible for home visits and follow-up care. Healthcare providers are paid from the same patient-allocated bundle to provide care that is coordinated within the team. The rationale behind this funding approach is that it motivates providers to consider the budget for each patient episode in a coordinated way, ensuring each patient receives the most appropriate care at the right time from the right provider (and in the right setting). By providing patients with more coordinated care, and ways to keep in touch with a member of the care team (e.g., a toll-free number to contact a member of the care team with access to health records 24/7), the approach also makes patients feel more comfortable outside of hospital settings.

Unique among organizations that are considered part of the specialty sector, but that are based within community settings, are two types of what can broadly be considered to be community-based specialty clinics. The first type includes Independent Health Facilities that provide a high volume of low-risk procedures that were traditionally provided in hospitals – both diagnostic (e.g., computed tomography or CT, magnetic resonance imaging or MRI, positron emission tomography or PET scans, sleep-study tests) and therapeutic (e.g., abortion, dialysis and many types of surgery). One example of such a facility is the Kensington Eye Institute in Toronto. The second type includes what are called Out of Hospital Premises, providing cosmetic surgery (which typically is not publicly funded), endoscopy and interventional pain management (see Chapter 6 for a more detailed description of the types of care provided in community-based specialty clinics). In both cases, these organizations are funded on a fee-for-service basis, however, Independent Health Facilities also receive facility fees for medically necessary services (Tables 3.5 and 4.6). In 2010-11, Independent Health Facilities received nearly $408 million in facility fees from the Ministry of Health and Long-Term Care, of which the majority (92%) were used to pay for diagnostic procedures and the remainder used for therapeutic procedures (Table 4.6).

Long-term care funding

The funding of long-term care homes in Ontario is characterized by a

combination of transfers from various sources. Public sources that help fund long-term care homes include:

1) the provincial health budget, either directly or through LHINs, which accounted for more than half (57%) of all long-term care homes' revenues in 2012;
2) the provincial social assistance budget and other government departments, which accounted for nearly 8% of revenues in 2012; and
3) direct transfers from municipalities and other agencies, which collectively accounted for nearly 6% of long-term care home budgets in 2012.(25)

These public sources of organizational funding are used to cover the professional (e.g., nursing) services, personal support services (e.g., bathing), and homemaking services (e.g., meals) provided in long-term care homes (Table 3.5). Payments are made through 'per diem' charges (which is a type of capitation budget calculated based on an average rate per resident per day), either alone or alongside a global budget, and can come from LHINs or directly from government.

Additional standardized charges for accommodation are paid for by residents (with a subsidy from the government for those who cannot afford it), with the charges set by the Ministry of Health and Long-Term Care. In 2012, these charges amounted to approximately 25% of total revenues.(25) Also, while not formally part of long-term care home budgets, standard physician fees based on the Ontario Health Insurance Plan (OHIP) Schedule of Benefits cover the medical care provided on a fee-for-service basis in long-term care homes.

Public health funding

Finally, local public health agencies are funded through a mix of program-based grants that function similarly to global budgets, with 75% coming from the Ministry of Health and Long-Term Care, and the remainder from municipalities. In 2011-12, nearly $680 million was spent on public health (approximately 1.5% of total public expenditures on the health system), with more than half ($368 million) allocated to local public health agencies, and the remainder spent on specific programs or on Public Health Ontario to support the delivery of programs (Table 3.4).

Remunerating providers

The third element in the process of financial flows through the Ontario health system concerns how the revenues raised are used to pay the health professionals responsible for providing programs and services to citizens (represented by part of the right side of Figure 3.1). The most costly and perhaps complex aspect of this process relates to what amounts to the second-largest source of public expenditures in the province after payments to LHINs: allocations made to OHIP to pay physicians, and to a much lesser extent, other healthcare providers. Transfers to OHIP accounted for approximately 37% of all public financial flows from the Ministry of Health and Long-Term Care in 2011-12, and close to $13 billion – or 76% of OHIP allocations – was spent on remunerating physicians in the same year (represented in Figure 3.1, with detailed expenditure breakdowns provided in Table 3.4).

Six options are generally considered when using public revenues to pay health professionals – also commonly referred to as remuneration:

1) fee-for-service (providers receive a fixed fee for each healthcare service performed);
2) capitation (providers receive a fixed fee for each patient under their care);
3) salary (providers receive a fixed income on a regular basis, which may vary depending on the hours worked);
4) episode-based payment (providers receive a pre-determined amount for particular types of diagnoses for an entire episode of care, regardless of the services performed);
5) fundholding (providers receive a fixed budget to cover all necessary care provided in their practice, often including prescription drugs, and to purchase the necessary secondary care for patients registered to their practice for a given period of time); and
6) targeted payments and/or penalties (providers receive additional payments/penalties for taking a measurable action or achieving a pre-determined performance target).

Professionals may also be given an indicative (or shadow) budget to guide their decisions about the amount of money available to care for their patients, and the optimal allocation of that budget, however, as was the case for organizational funding, this is not used to determine the actual remuneration they receive.

Historically, fee-for-service has been the main option used to remunerate physicians, while nurses both in home and community care settings and in hospitals, for example, have received salaries (paid for out of organizational budgets). However, provider remuneration has shifted a great deal in the last decade and a half, particularly for physicians, many of whom are now paid using a complex array of mixed remuneration models.

Physician remuneration

The specifics of physician remuneration are typically negotiated between the Ontario Medical Association and the Ministry of Health and Long-Term Care under the terms of a Physician Services Agreement, the last one having been negotiated for the period of October 2012 through March 2014 inclusive.(26) Since the conclusion of the last Physician Services Agreement, and during the period in which the two parties have been unable to reach a new agreement, the government has made several unilateral cuts to physician fees, but also clarified that the *Patients First Act, 2016* will not delegate to LHINs the authority to negotiate physician contracts on behalf of the Ministry of Health and Long-Term Care.

While nearly two thirds of all physician remuneration continues to be paid through fee-for-service, whereby physicians bill OHIP for each service they provide to patients based on the rates outlined in the Schedule of Benefits for Physician Services (see the OHIP box in Figure 3.1), the other one third is now covered through a range of alternative payments (Table 3.6). This is a dramatic shift from the roughly 92% of physician remuneration paid through fee-for-service and 8% of remuneration paid through alternative payments in 2000-01 (Table 3.6). This general breakdown is similar for family physicians and specialists, although the ways in which different remuneration models are mixed with fee-for-service differs between these two groups.

In parallel with dramatic shifts in how primary care is organized in Ontario (see Chapter 6 for more detail), family physicians are increasingly paid through a number of blended mechanisms depending on the primary-care model in which they practice (Table 3.7). For example, physicians working in a Family Health Team are paid through one of blended capitation, blended salary or blended complement-based (full-time equivalent) payments. Some other models rely on blended capitation payments (for physicians working

Table 3.6: Public health expenditures on physicians, by type of physician-remuneration mechanism[1]

Category of payments ($ thousands)	Ontario			Canada
	2000-01[2]	2010-11	2013-14	2013-14
Total clinical payments to physicians	4,535,118	7,320,013	8,191,649	23,681,424
Fee-for-service clinical payments to physicians	4,161,511	4,800,351	5,176,714	16,859,685
Alternative clinical payments to physicians	373,607	2,519,661	3,014,935	6,821,739
Average gross clinical payment per physician	—	297,864	304,658	330,317

Sources: 8; 100-103

Notes:
[1] Inflation adjusted to 2002, according to Statistics Canada's Consumer Price Index (healthcare), CANSIM 326-0020: value x (CPI 2002/CPIi) = value (2002) where i = year
[2] Data not available for the specific reference period are denoted by —.

in Family Health Networks and Family Health Organizations) or salary (for physicians working in Community Health Centres). The Schedule of Benefits also includes a number of pay-for-performance billing codes that are unique to family physicians, such as premiums for services billed outside of regular work hours, and annual bonus payments for meeting particular targets (e.g., number of house calls for complex and continuing care patients).(27) We return to financial incentives below.

Specialists are compensated either through fee-for-service entirely (with billings working in a similar way to primary care), or a range of other blended 'alternative funding plans' or 'alternative payment plans', which are contracts between groups of specialist physicians and the Ministry of Health and Long-Term Care.(28) However, the fee billed for these services is dependent on a referral from a family physician: if a patient is not referred, the specialist receives a lower fee for the same service.(29) Specialists engaged in 'alternative funding plans' or 'alternative payment plans' usually work in university teaching hospitals and have a mix of clinical, teaching and research commitments. These specialists are remunerated through a number of blended models that often utilize base rates with additional incentive payments, and which sometimes incorporate a fee-for-service component. Other remuneration models used in 'alternative funding plans' and 'alternative payment plans' include: 1) global/block funding for specific services or locations; 2) blended models that include a base rate for clinical services, teaching, research and administration plus premium payments; 3) payments made based on bed utilization rates; and

Table 3.7: Primary-care organization-funding mechanisms and physician-remuneration mechanisms in use

Model	Primary-care payment methods					
	Fee-for-service[1]	Fee-for-service with programmatic capitation[2]	Blended capitation[3]	Blended salary[4]	Blended complement[5]	Salaried
No model	✓					
Comprehensive Care Model		✓				
Family Health Groups		✓	✓			
Family Health Neworks			✓			
Family Health Organizations			✓	✓	✓	
Family Health Teams[6]						
Community-Sponsored Family Health Teams				✓		
Rural and Northern Physician Group Agreement					✓	
Community Health Centres						✓

Sources: 104-107

Notes:
[1] Fee-for-service is billed through the Ontario Health Insurance Plan and is based on the Schedule of Benefits for Physician Services.
[2] Programmatic capitation provides monthly comprehensive-care capitation payments for patients enrolled in programs (e.g., chronic-disease management programs).
[3] Blended capitation provides a fixed payment per patient, adjusted for age and sex for a predetermined set of primary-care services, while fee-for-service payments are given for other services that fall outside of the capitation model.
[4] Blended salary provides a base salary determined by the number of enrolled patients (e.g., a roster of fewer than 1,300 patients is considered part-time), as well as incentives, premiums and special payments for the provision of specific primary healthcare services.
[5] Blended complement provides a base payment determined by the number of physicians in the group, as well as incentives, premiums and special payments for the provision of specific primary healthcare services. The compensation model is available to identified communities with an underserviced designation for the provision of primary healthcare services and emergency services.
[6] Family Health Teams have the option of one of three compensation models: blended capitation, blended salary or blended complement.

4) sessional payments plus fee-for-service billings.(30) In the 2012-13 fiscal year, 18% of the $7.1 billion the Ministry of Health and Long-Term Care paid to specialist physicians was under an alternative funding arrangement, with an estimated 50% of all specialists, and 90% of emergency department physicians paid at least in part through this mechanism.(31)

While some physicians – both family physicians and specialists – receive private payments for services not covered publicly, this accounts for less than 1% of all private expenditures in Ontario (Table 3.3).

In addition to the unique mix of mechanisms used to remunerate physicians in Ontario, there are a number of noteworthy aspects related to: 1) what their earnings are meant to cover; 2) how their 'retained' earnings are taxed; 3) how their retirement is planned for and their benefits are paid; and 4) how their gross or net income is not publicly reported as it is for other high-earners in the health system.

First, most physician earnings are typically meant to cover the overhead costs involved in operating their private practice, such as office space, equipment, malpractice insurance premiums, and staff. These staff can include those to whom physicians can delegate tasks (e.g., physician assistants) while billing OHIP for a medical service.(32) Taking overhead into account has been found to substantially affect estimates of what physicians actually 'take home' as pay, with the significant variations in how much overhead is paid translating into significant variations in net income across specialties.(33) For example, based on one study's analysis of billing information and public payments only, ophthalmologists appear to be one of the highest-paid specialties (ranked second to diagnostic radiologists), although their income is eighth on the list once overhead is taken into account.(33) Furthermore, the same study also found that nearly 90% of ophthalmologists report that more than 30% of their income goes towards keeping their practice running, which is much higher than those reporting similar overhead costs as a proportion of income in family medicine (68%), cardiology (48%), diagnostic radiology (31%) and anaesthesia (10%).(33) It should be noted that these figures do not take into account certain specialists' opportunities to generate non-OHIP revenue (e.g., ophthalmologists frequently rent out space to opticians). Like many other health professionals, physicians are also required to cover some of the costs of paying malpractice insurance premiums out of their income, which also contributes to their overhead costs. In 2017 the average fee paid by Ontario physicians to the Canadian Medical Protective Association will be $9,991, although the fee can vary significantly by specialty (e.g., in 2017 an Ontario dermatologist will pay $7,092 whereas an Ontario obstetrician will pay $99,072).(34) The provincial government reimburses physicians for at least a portion of these fees (with some estimates suggesting this number is as high as 83%), and in 2008 the government paid approximately $112 million to physicians for this reason.(35)

Second, most physicians earn income through a corporation, whether as a

medicine professional corporation (e.g., many family physicians and specialists in private practice) or as a partnership or corporation (e.g., many specialists in teaching hospitals), so their retained earnings (i.e., their earnings after expenses like overhead costs have been deducted from their earned income) are taxed at a corporate rate (15% for the first $500,000), rather than at a personal rate (53.53% for income above $220,000). They can also benefit from the federal government's small business deduction (although this may be changed under the terms of proposed legislation). While physicians will need to pay personal income tax on the income they draw from their corporation, the assets left within the corporation are able to accrue from a more generous starting position. Additionally, tax rates will be different if physicians withdraw this income as dividends (rather than as personal income), and by naming spouses and children as co-owners of the corporation they may also benefit from splitting income in ways that effectively lower tax rates on withdrawn income.

Third, most physicians – as business owners – must plan for their own retirements and pay for other benefits that are typically earned by salaried employees. Physicians typically are not able to participate in the pension plans administered by, say, the hospitals where they work (although there may be some exceptions among the minority of physicians who are paid by salary). However, as a benefit of their membership in the Canadian Medical Association (CMA), they can invest their personal and corporate assets in MD Management, a wholly owned subsidiary of CMA that can provide preferred rates to CMA members and their families. Additionally, most physicians are also required to cover the costs of paying for their own benefits packages (e.g., private insurance premiums to cover prescription drugs, dental services and vision care).

Fourth, neither physicians' gross income nor their net income (i.e., their earnings less their overhead costs and personal or corporate tax payments) is publicly reported on the province's 'sunshine list' as is the gross income for other high-earners in the health system and broader public sector (i.e., those earning more than $100,000 per year), and as it is for physicians in the health systems of provinces like B.C. and Manitoba.(36)

Other providers' remuneration

The remuneration of nurses and many other regulated health professionals

and many unregulated health workers is negotiated very differently, typically through collective bargaining between unions (e.g., Ontario Nurses' Association and Ontario Public Service Employees Union) and the organizations that employ and pay these individuals (e.g., hospitals), not with government. The Ontario Nurses' Association represents approximately 62,000 registered nurses, registered practical nurses, and nurse practitioners (although the vast majority are registered nurses) and it negotiates wages, benefits, employment conditions and other issues through a mix of master contracts, such as the Hospital Central Agreement with the Ontario Hospital Association,(37) and local contracts (via local bargaining units). The Ontario Public Service Employees Union represents a broader array of professionals and workers, including 12,000 staff in more than 250 occupations (e.g., laboratory and radiation technologists, laboratory assistants, physiotherapists, occupational therapists, social workers and pharmacy technicians) in hospitals alone.(38) Other unions also engage in collective bargaining in the health system. Occasionally payment rates are explicitly set by government, as has been done for publicly paid personal support workers, whose hourly base wage was increased over three years by $4.00 to $16.50 per hour.(39) Many factors, only one of which is the bargaining strength of unions, explain the significant differences in wages, benefits and employment conditions across sectors that complicate efforts to, for example, transition care from hospitals to the community.

Unlike physicians, many health professionals receive private payments for services not paid for publicly (e.g., dental services), whether directly from patients through out-of-pocket payments or indirectly through fee-for-service payments from private insurers. As of 2013, these payments accounted for almost 29% of all private expenditures, which was almost as much as drugs (which accounted for 33%), and more than double what is paid privately to hospitals (Table 3.3).

Financial incentives

In addition to the options outlined above, Ontario has also utilized targeted payments and/or penalties (option 6) over the last decade and a half in order to incentivize specific provider behaviors. While all of the system financing, organizational funding and professional remuneration mechanisms discussed thus far create incentives, in this section we focus on targeted payments or penalties that seek to achieve particular health-

system goals, and that are layered on top of, or operate alongside, existing financing, funding and remuneration mechanisms. In Ontario, these have mostly been characterized by individual bonuses paid directly to health professionals and managers, and included incentives for:

- encouraging community pharmacists to support smoking cessation among Ontario Drug Benefit (ODB) Program recipients;(40)
- supporting family physicians to provide flu shots for seniors, toddler immunizations, Pap smears, mammograms, and colorectal cancer screening;(41; 42)
- encouraging family physicians to engage in diabetes assessment and diabetes management;(43-45)
- encouraging surgeons to use laparoscopic techniques for colon surgery;(46)
- improving the recruitment (47) and retention (48) of physicians in rural and northern Ontario;
- encouraging allied health professionals to practise in northern Ontario;(49) and
- supporting senior hospital executives to achieve performance-improvement targets.(50)

Ontario has experienced variable results in introducing financial incentives targeted to individual health professionals, with evaluations indicating that they can help improve diabetes care, and increase the use of specific surgical methods for performing colon and rectal cancer surgery.(43; 44; 51) Additional details about Ontario's experience with financial incentives can be found in the McMaster Health Forum's evidence brief on the same topic.(52)

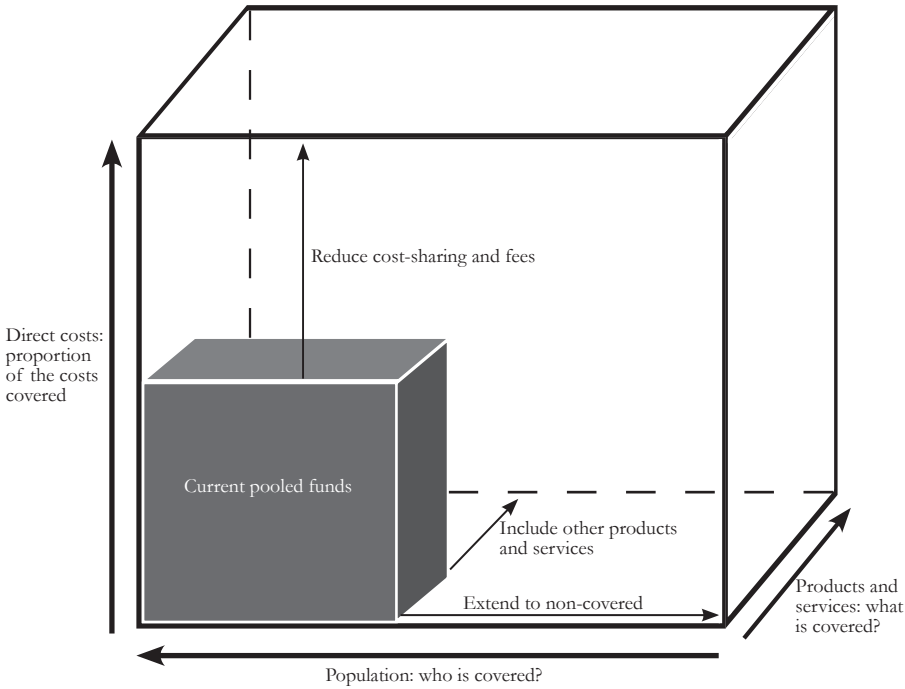
Purchasing products and services

The fourth element in the process of financial flows through the health system involves purchasing the products and services that are used by citizens (represented by the double line at the top of Figure 3.1). While the language 'providing programs, services and drugs' works well in terms of what healthcare providers do, we use the term 'purchasing products and services' when discussing this element of financial flows. The process of financial flows through the health system determines the nature of coverage for products and services, and the extent to which universal (public) coverage for products and services has been established in the province.

The World Health Organization has proposed three dimensions that can assist with describing the extent of universal coverage in a particular health system, including defining who is covered in the population, what is covered, and the proportion of the direct costs covered.(53; 54) Figure 3.3 provides an illustrated representation of these dimensions. As an orienting framework, it shows that, in making decisions about the nature of coverage in a particular health system, policymakers generally grapple with three types of decisions:

1) whether to extend coverage to populations not currently covered (represented in Figure 3.3 by the line on the horizontal axis at the front of the cube);
2) whether to include other products and services not currently covered (represented by the line on the axis from the front to the back of the cube); and
3) whether to reduce or remove cost-sharing and fees for certain products and services (represented by the line along the vertical axis of the cube).

Figure 3.3: Three dimensions to consider when moving towards universal coverage



Furthermore, the details within each of these dimensions of coverage can be established through a number of different options:

1) making changes to the scope and nature of insurance plans;
2) establishing and iteratively revising lists of covered/reimbursed organizations, providers, and products and services;
3) placing or removing restrictions in coverage/reimbursement rates for organizations, providers, and products and services;
4) placing caps on coverage/reimbursement for organizations, providers, and products and services;
5) establishing prior approval requirements for organizations, providers, and products and services (e.g., requiring organizations or providers to obtain authorization from third-party payers/healthcare administrators before delivering a product or service); and
6) adjusting the lists of substitutable products and services (e.g., establishing which products and services are not currently covered or may be substituted for similar covered products and services).

In Ontario, the first three have been used most frequently in determining the nature of coverage in the health system, whereas the others – while used to some extent in specific instances – are not used as visibly or in as many circumstances. As already noted in the introductory chapter of this book, the core bargain stipulates that all citizens in Ontario (i.e., who is covered) receive hospital-based and physician-provided services deemed 'medically necessary' (i.e., what services are covered) for free at the point of use (i.e., the proportion of direct costs covered). In fact, under the *Commitment to the Future of Medicare Act, 2004* (and like some other provinces), physicians cannot accept payments from private insurers or from patients for medically necessary services that are publicly insured. Coverage even extends to medically necessary hospital-based and physician-provided care received in other parts of Canada. Ontarians receiving such care in another province or territory are covered up to the equivalent amount of the Ontario rate for the same service, either through the hospital or physician billing the Ministry of Health and Long-Term Care directly (all provinces except Quebec), or by paying the charges themselves and then being reimbursed by the Ministry of Health and Long-Term Care (all provinces).(55) Formal reciprocal billing agreements exist between Ontario and all provinces and territories except Quebec, although it operates in a similar way despite the lack of a formal agreement. No similar arrangement exists for home care.

While medically necessary hospital-based and physician-provided care is free at the point of use for all Ontarians, one organization has estimated that roughly 200,000 people living in the province may not be covered by OHIP at any given time.(56) As such, these people may have to pay out-of-pocket for healthcare services or forgo them if they cannot afford to pay (although they will not be turned away if they are extremely sick). This number includes individuals who are subject to a three-month waiting period established by the government for OHIP eligibility, such as: new immigrants, temporary foreign workers, returning Canadian citizens who have been out of the country for more than 212 days in the previous year (57) and who have not met continuous OHIP eligibility requirements,(58) international students who have not purchased the private health insurance usually mandated by colleges and universities, and non-status people (i.e., those who lack citizenship/immigration status). Some Community Health Centres provide healthcare services (free or for a small fee) to people who do not have a valid health card.(59)

Certain groups may be exempt from the three-month waiting period, with the most recent example being Syrian refugees. Most refugees (including those arriving from Syria) are also eligible for the Interim Federal Health Program, which is provided by the federal government to provide them with access to healthcare services immediately upon arrival and until registration with a provincial health-insurance plan is completed. After the Conservative Government limited benefits under this program in 2012 to those posing a public-health threat, an expanded version was re-introduced by the Liberal Government in 2016.(60) The program now also covers supplementary benefits (e.g., prescription drugs, dental services, and vision care) for refugees who have registered with a provincial plan, as well as services provided before resettlement in Canada (e.g., the immigration medical examination, pre-departure vaccinations, services to manage disease outbreaks in refugee camps, and medical support during travel for those who need it).(61)

The broad coverage trends outlined above become considerably more complicated when considering the nature of coverage for products and services across each sector. In Table 3.8, we provide an overview of the nature of coverage across each sector. Below, we discuss each sector briefly, focusing on who is covered, what is covered, and which costs are covered. When considering what is covered, it is important to note that coverage can and

does change as new products (e.g., prescription drugs) and services (e.g., physician services) are added to the list of those that are covered (e.g., by ODB and OHIP, respectively), and as other services (some of which may no longer be the most cost-effective option) are 'delisted' – a process that is often referred to as 'disinvestment.' The government publicizes additions and delistings through the ODB Program (www.formulary.health.gov.on.ca/formulary/) and OHIP (www.health.gov.on.ca/en/pro/programs/ohip/bulletins/). When appropriate, we also refer to tables introduced earlier in this chapter to illustrate the nature and extent of costs covered.

Because the aim in this chapter is to focus on the big picture of how products and services are purchased publicly in the province (and thus the nature and extent of public coverage), we do not provide an overview of all the products and services that fall within each sector, or that are provided for select conditions, as part of select treatments or for the select population of Indigenous peoples (which are covered in Chapters 6-9, respectively), nor do we provide a list of those that are not covered. However, we do flag when an important coverage gap exists, such as for prescription drugs, which we turn to first.

Table 3.8: Public coverage of programs and services, by sector[1]

Population covered	Services covered[2]	Costs covered[3]
Prescription drugs		
All seniors and Ontarians with high prescription drug costs relative to their household income holding a valid health card	• Prescription drugs • Select over-the-counter drugs	Partial (patients pay a means-tested deductible and co-payments on each prescription)
Other technologies		
All Ontarians with a valid health card who meet eligibility requirements	• Medical devices • Assistive devices • Laboratory tests	Full coverage when ordered by a physician for necessary medical devices and laboratory tests, partial coverage (75%) for most necessary assistive devices, although Ontarians in financial need may be eligible for additional financial support
Home and community care		
All Ontarians with a valid health card	• All services approved by a Community Care Access Centre (CCAC) (professional, personal support and homemaking services)	All when approved by a CCAC (no public funding otherwise)

Continued on next page

Population covered	Services covered[2]	Costs covered[3]
Primary care		
All Ontarians with a valid health card (or recent immigrants with a temporary card)	• Medically necessary family physician services (or services provided by health professionals working in physician-led interprofessional teams) • Primary-care services in community-governed primary-care organizations (e.g., Community Health Centres, Aboriginal Health Access Centres) • After-hours care and walk-in clinics • Midwifery and diabetes services • Travel to/from necessary health services that are more than 100 km away from place of residence (through the Northern Health Travel Program) • Dental and optometry services not covered	All with some exceptions (Northern Health Travel Program only covers partial travel and accommodation costs for those who have to travel more than 100 km one way to access health services)
Specialty care		
All Ontarians with a valid health card	• Urgent care • Emergency health services • Hospital services • Specialty programs • Complex continuing care	All with some exceptions (co-payment of $45 dollars for ambulance if medically necessary and $240 if not, and emergency air ambulance only covered if physician ordered; additional costs for private hospital rooms, private duty nurses and ambulatory aids such as canes and walkers)
Rehabilitation care		
All Ontarians with a valid health card	• Rehabilitation services provided at home (when deemed eligible by a CCAC), in community settings (when deemed eligible for care in a Community Physiotherapy Centre), and in both hospitals and long-term care homes (when needed)	All when these conditions are met (no public funding otherwise)
Long-term care		
All Ontarians with a valid health card	• Assistance with admission to a long-term care home (provided by staff at CCACs) • Professional, personal support and homemaking services in long-term care homes • Standardized accommodation charges are not covered unless the resident is eligible for a subsidy	All approved professional, personal support and homemaking services Partial for residents needing financial assistance with accommodation charges
Public health		
All Ontarians in public health unit area (and those with a valid health card for individually targeted vaccination programs)	• Population-based strategies (e.g., health promotion, infectious and chronic disease prevention and control, environmental health) • Individual-level services (e.g., influenza immunization program)	All

Continued on next page

Population covered	Services covered[2]	Costs covered[3]
Other: Information services		
All Ontarians	• Assistance with finding local healthcare services (Health Care Options program) • Assistance with finding a primary-care provider (Health Care Connect) • Advice from a registered nurse over the telephone (Telehealth Ontario)	All
Cross-sectoral: Health Links		
All Ontarians with a valid health card	• A range of programs and services designed to support patients with complex needs (ideally without admission to a hospital)	All

Sources: 89; 108-112

Notes:
[1] For a more comprehensive description of each sector including the policies, programs, places and people involved in it, see Chapter 6.
[2] For a more comprehensive description of each service, see Chapter 6.
[3] Full=100% publicly financed; partial=services not entirely financed publicly, patient co-payment and/or specific eligibility criteria may apply

Coverage of prescription drugs and other 'technologies'

As the introductory chapter in this book highlighted, there are many products and services that are not currently covered by the core bargain and are therefore often financed and paid for privately. The most visible omission from the basket of covered products and services in Ontario is prescription drugs. At present, 65% of prescription drug costs are paid for privately (Figure 1.2), either through direct out-of-pocket spending or through premium contributions to private-insurance plans, which are often linked to employment. As of 2013, 18% of all direct out-of-pocket healthcare spending by households was for prescribed medicines and pharmaceutical products (Table 3.2), which we refer to as prescription drugs in Chapter 8.

However, while prescription drugs are not covered for the majority of the population in Ontario, there are additional programs that aim to provide some coverage for specific segments of the population. The ODB Program provides prescription drug coverage to all seniors in the province. It also covers the cost of select over-the-counter drugs that meet one or more of the following criteria:

- there are no alternatives, and lack of access could lead to a serious medical crisis;
- there are only toxic and/or more costly alternatives;
- they are needed for use with another ODB-covered drug product; and

- they are used to treat a serious disease that can be passed on to others, such as tuberculosis.(62)

The program does not cover all costs, however, and includes an annual means-tested deductible, as well as a $2 co-payment for each prescription (Table 3.8). The Trillium Drug Benefit is targeted to lower-income Ontarians who have high prescription drug costs relative to their household income. Similar to the ODB Program, those eligible for the Trillium Drug Benefit pay an annual means-tested deductible and a co-payment per prescription. Chapter 8 provides a more detailed description of these programs.

Three types of other 'technologies' are covered publicly, in full or in part, in Ontario: 1) assistive devices; 2) medical devices; and 3) laboratory tests. For assistive devices, the Ministry of Health and Long-Term Care oversees the Assistive Device Program, which helps Ontarians who have lived with a disability for six months or longer pay for assistive devices such as wheelchairs, positioning and ambulation aids, communication aids, enteral feeding aids, diabetic supplies, ostomy supplies, hearing and vision aids, orthotics and prosthesis aids, respiratory aids and pressure modification aids.(63) For most devices, 75% of the costs are covered, as long as a physician has provided a diagnosis and prescription, with the remaining cost covered privately (either through out-of-pocket spending or a private insurance plan).

As a complement to this program, the Ontario Disability Support Program, which is administered by the Ministry of Community and Social Services, helps Ontarians in financial need pay for costs not covered by the Assistive Devices Program. Support is also provided for some devices not covered by the Assistive Devices Program (e.g., bathroom aids, computer and access technologies, and life alert systems). Additionally, CCACs provide support with respect to assistive devices by enabling Ontarians who are deemed by an occupational therapist to be at risk for falls and mobility issues to use mobility aids and safety devices for a 28-day trial while they apply for coverage through the Assistive Devices Program.

Both medical devices (e.g., heart monitors) and laboratory tests (e.g., bloodwork) that are deemed necessary and ordered by a physician are fully covered. However, certain devices (e.g., medication pumps) and tests (e.g., vitamin D deficiency testing) are not covered by the government and must

be paid for privately, again either through out-of-pocket spending or a private insurance plan.

Coverage by sector

Home and community care

The many for-profit, not-for-profit and public organizations that provide home and community care to Ontarians are funded in whole or in part by CCACs. Any Ontarian can directly approach a CCAC and receive services at no charge from staff, who are able to: 1) provide information about home and community care (and long-term care) options, regardless of whether they are funded by the government; 2) determine eligibility for government-funded services and settings; 3) arrange for and coordinate the delivery of government-funded professional, personal support and homemaking services for people living in their own homes, and for school children with special needs (i.e., home care); and 4) make arrangements for admission to (or for getting on the waiting list for) many day programs and supportive housing programs (i.e., community care), as well as to some chronic care and rehabilitation beds, and all long-term care homes (which we turn to later in this chapter).

Ontarians who are deemed eligible by the CCAC get full or partial coverage for the following government-funded services: 1) professional services, which include assessing a client's needs, providing care or helping the client to care for herself (and the client's family to cope); 2) personal support services, which include helping clients with daily care or helping clients to safely manage these activities on their own, and can range from help with getting in and out of bed or a chair to bathing, dressing (and undressing), eating, personal hygiene (e.g., mouth and hair care), and toilet hygiene; 3) homemaking services, which include housework (e.g., cleaning, doing laundry), planning and preparing meals, shopping for food or clothing, managing money, and caring for children; and 4) end-of-life care at home.

Primary care

As already mentioned a number of times in this chapter and throughout this book, in the primary-care sector, all Ontarians have full coverage for medically necessary physician-provided services and for services provided by health professionals working in physician- or nurse practitioner-led

interprofessional teams. Midwifery services and some targeted diabetes support services are also covered. The Northern Health Travel Program provides financial assistance for Ontarians who have to travel long distances to access needed healthcare services, although coverage only includes some transportation and accommodation costs, calculated based on the number of kilometres travelled (see Table 3.8).

There are also some important omissions in primary-care coverage in Ontario – particularly for dental services and vision care (specifically optometry services). Ninety-three percent of spending on other health professionals (including care provided by dentists and optometry professionals) is paid for privately in the province (Figure 1.2). Twenty-seven percent of all direct out-of-pocket household spending is on dental services and vision care (16% and 11%, respectively), while 5% of all health insurance premiums are for dental services (Table 3.2).

Specialty care

Most types of medically necessary specialty services are fully covered for all Ontarians. These include:

- care provided in urgent-care centres (e.g., hospital-based services addressing non-emergencies requiring immediate attention);
- emergency healthcare services (e.g., dispatch centres, ambulance services, base hospitals and emergency rooms);
- medically necessary hospital services (e.g., emergency and acute care, specialist services and mental health and addictions services provided in hospitals);
- specialty programs (e.g., internal medicine, surgical specialties, anesthesia, obstetrics and gynecology, pediatrics, psychiatry, radiology and laboratory medicine); and
- complex continuing care (e.g., long-term medically complex care that cannot be provided in long-term care homes or in the patient's home).

There is no formal limit on the number of second opinions that patients can obtain from specialists, as long as they get a referral from a family physician or a specialist they have visited within the last 12 months.

While most costs are fully covered for all of the above types of specialty care (if deemed medically necessary), there are some costs that individual Ontarians have to cover privately. First, Ontarians pay a $45 co-payment

for land ambulance services if medically necessary, and $240 if a land ambulance is used for something that is not considered medically necessary. For air ambulance services, Ontarians are fully covered as long as the services are ordered by a physician (a type of prior approval requirement referred to in option 5 above). Second, hospital parking, particularly for patients and caregivers who need to visit the hospital often, has been found to place a significant financial burden on frequent visitors, and in some instances they create a financial barrier to accessing needed care or providing support to someone who does. These costs are still covered out-of-pocket by Ontarians, although as of October 2016, hospitals that charge more than $10 per day were mandated to reduce their fees by 50% on five-, 10- and 30-day passes, and ensure such passes are transferrable (across people and vehicles), provide in/out privileges, can be used for consecutive or non-consecutive days, and are valid for up to a year after purchase.(64)

Rehabilitation care

Rehabilitation services are unique in that they are a key element of many sectors (i.e., home and community, primary, specialty and long-term care), and they have been more extensively 'privatized' than services in other sectors, given shifts towards more private payment and more private for-profit delivery (additional details for which are provided in Chapter 6). However, there are a number of rehabilitation services that are covered by government funds. Specifically, Ontarians are covered for professional rehabilitation services provided at home (when deemed eligible by a CCAC), in community settings (when deemed eligible for care in a Community Physiotherapy Centre), and in both hospitals and long-term care homes (when needed).

Ontarians may also be eligible for other 'third-party' funding for rehabilitation services if they have a work-related injury or disease (through the Workplace Safety and Insurance Board if eligible) or have been injured in an automobile accident (through their automobile insurance). Outside of these scenarios, most patients pay for rehabilitation services provided in privately owned and operated clinics/practices using their own money, or by drawing on private insurance coverage.

Long-term care

As noted above, long-term care homes provide a mix of professional,

personal support and homemaking services, all of which are publicly covered, whereas residents pay a standardized accommodation charge (although this may be subsidized depending on a resident's ability to pay). Some Ontarians may be covered for these additional costs if they hold long-term care insurance through their private insurer.

Public health

All Ontarians can benefit from population-based strategies (e.g., health promotion, chronic-disease prevention, infectious disease control and environmental health programs) and obtain many individual-level services (e.g., influenza immunizations) without paying directly out-of-pocket or through insurance premiums. However, only some Ontarians are eligible to receive services such as dental services (which we discuss in Chapter 6).

Cross-sectoral and other programs

A range of information services are also available to all Ontarians free at the point of use, such as Health Care Options (providing assistance with finding local healthcare services), Health Care Connect (providing assistance finding a primary-care provider), and Telehealth Ontario (advice provided by a registered nurse over the telephone). Health Links, a cross-sectoral initiative that includes a range of programs to support patients with complex needs, ideally without being admitted to hospital emergency departments, is also fully covered.

Incentivizing consumers

The fifth and final element in the process of financial flows through the health system is not an element in the process per se, but a consequence of the other financial arrangements in the province (represented at the top of Figure 3.1). As with all other financial arrangements considered in this chapter, there are a number of options available to governments and other third-party payers to incentivize the behaviour of individual 'consumers' of healthcare. For citizens, incentives may be used to encourage engagement in healthy behaviours, effective self-management or appropriate care seeking. Options for achieving these behaviours include:

1) setting the level and features of premiums (establishing the amount paid out-of-pocket by individuals to be enrolled in, and receive healthcare

coverage from, an insurance scheme);
2) cost-sharing (requiring patients to pay a portion of the costs of products and services);
3) health savings accounts (allocating funds to individual savings accounts earmarked for purchasing products and services, thereby shifting the responsibility for purchasing them to the patient); and
4) targeted payments and/or penalties (giving money to households on the condition that they comply with behavioural requirements).

While there are several examples of financial incentives targeted at health professionals and organizations in Ontario (see above), there are few (if any) intentionally targeting citizens, and the aforementioned options for incentivizing consumers have not been widely used in the province. Premiums paid to private insurers to cover products and services not covered publicly, cost-sharing for prescription drugs (including the co-payments required by both government drug benefit programs as well as private insurance plans), and cost-sharing for prescription lenses and dental services in private insurance plans (which also require patient co-payments or deductibles) can all be viewed as financial (dis)incentives – particularly for prescription drug use, given that reductions in use are typically seen with drug co-payments. However, the payment of premiums and existence of cost-sharing may be viewed more accurately as a consequence of past decisions about what is covered and what is not, rather than the result of intentional policies that align with broader health-system goals introduced by government.

Conclusion

The financial arrangements that characterize Ontario's health system consist of a unique mix of options that define how revenue (i.e., money) flows through the system. This process is represented in Figure 3.1, starting at the top left corner and moving counter-clockwise through the figure. Throughout this chapter we have covered many of the specific details related to how the system is financed (i.e., element one in the process concerning how revenue is raised), how organizations are funded (i.e., element two in the process concerning how revenues are allocated to organizations), how health professionals are remunerated (i.e., element three in the process concerning how revenues are used to pay providers), how products and services are purchased publicly (i.e., element four in the process whereby

revenues become the programs, services and drugs used by citizens) and how consumers are incentivized (which are typically the consequences of other financial arrangements in the system).

Despite the importance of the many specific details covered throughout this chapter, there are five defining aspects of financial arrangements in Ontario's health system that readers interested in the 'big picture' can take away. First, Ontario's health system is mainly financed through taxes that pay for publicly covered programs, services and drugs, although a significant amount is financed privately – either through direct out-of-pocket payments, or through premiums to private insurance plans – to pay for products and services that are not publicly covered (e.g., most prescription drugs, dental services). Second, LHINs receive the greatest proportion of public revenues in order to fund a number of organizations in the health system, such as hospitals and CCACs that are in turn responsible for purchasing services from home and community care organizations. Generally, such funding is approached through a mix of global budgets and other approaches. Third, physician remuneration through OHIP constitutes the largest proportion of public money earmarked for a specific category of health professionals, and while fee-for-service has traditionally been the dominant form of payment, this has changed to include a wider range of blended approaches to remuneration (particularly in the primary-care sector). Most other health professionals, including nurses, are paid salaries. Fourth, medically necessary hospital-based and physician-provided services are fully covered for all Ontarians, and a range of other services across sectors are also covered. Notable exemptions in coverage include prescription drugs, dental services, and optometry, all of which are paid for privately by citizens, either through out-of-pocket payments or through premiums paid to private insurance plans. Fifth, while these omissions were not designed to affect how Ontarians use healthcare services, they may create disincentives for accessing non-covered products and services.

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