PROVIDING CHIROPRACTIC SERVICES TO THOSE MOST VULNERABLE: FULFILLING MINISTRY OF HEALTH AND LONG-TERM CARE PRIORITIES

Report to the Ontario Chiropractic Association

March 1, 2007

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EXECUTIVE SUMMARY

On December 1st 2004, the Ontario government de-listed chiropractic services from the basket of goods and services that it provides to Ontarians. This has been especially harmful to vulnerable populations who generally do not have private health insurance. This paper sets out to provide funding options for consideration to "re-list" chiropractic services to the total Ontario population, as well as to Ontario's seniors, working poor and those on social assistance. Research supporting this paper will also demonstrate that the funding of chiropractic services for these groups will result in the provision of better healthcare at a lower cost across the healthcare system.

The de-listing of chiropractic services has negatively affected chiropractic patients, chiropractors themselves, and other health professionals. Changes reported by chiropractors since de-listing include fee increases, decrease in use of services by vulnerable populations, and an increase in the use of hospitals and family physicians. The de-listing of chiropractic services was a form of cost shifting not just limited to the shifting of fees paid from government to the individual. De-listing also shifted short term reimbursement costs of simple treatment to become longer term costs of much more complicated and prolonged treatment

Compensation for chiropractic services in an evolving health care system is a more complicated issue than for other professionals. The lack of clear direction related to funding represents an opportunity to provide possible solutions.

The following paper explores five funding models, namely a fee-for-service model, a capitation model, a blended model, a mixed population model and a sessional model. The fee-for-service model has the Ministry paying a chiropractor a fixed amount for each visit by a patient with the patient paying a co-payment amount as well. The capitation model would see the Ministry pay a chiropractor a fixed amount per patient per year with the patient paying a co-payment per visit. In the blended model the Ministry would pay a chiropractor a set "base" fee for every patient that signs on to his/her care, a fee per visit (less than the fee-for-service in the first model), as well as the patient paying a co-payment. The mixed population model uses the fee-for-service model for those patients not enrolled in some form of reformed primary care practice, and the capitation model for those who are. Finally, under the sessional model each chiropractor would be paid a sessional fee for services provided to patients enrolled in reformed primary care practices with the patient paying a co-payment amount as well. Each model explores the financial impact of providing partial funding for chiropractic services and a summary of the Ministry of Health and Long-Term Care (MoHLTC) costs is provided below:

MODELS
Fee-for-service model

This model assumes that for each visit by a patient to a chiropractor, the chiropractor will receive a fixed amount. The Ministry will have to decide whether they will pay the FFS for all residents of Ontario, or only for the most vulnerable populations. Impact calculations for both populations are below. As well, calculations have been made for a maximum number of visits to be paid by government and an average number of visits by each population

Capitated model

Under this model each chiropractor will be paid a fixed amount by the Ministry of Health and Long-Term Care for each patient under their care. Each patient will be required to pay a co-payment for each visit to the chiropractor.

This model is focused on eligible patients enrolled (or anticipated to be enrolled) in existing primary care practices: Family Health Teams (FHT), Family Health Networks (FHN), Family Health Groups (FHG), Rural and Northern Physician Group Agreements 1&2 (RNPG), Community Health Centres (CHC), Aboriginal Health Access Centres (AHAC), Health Service Organizations (HSO), the Group Health Centre - Sault St. Marie, and Primary Care Networks (PCN)

Blended Model

A blended model will provide the chiropractor with a set 'base' fee of $75 for every patient that signs on to their care. The chiropractor will additionally receive a set amount of $10 for each office visit. As with the previous two models, the MoHLTC will have to decide whether they will pay for all residents of Ontario, or only for the most vulnerable populations. Impact calculations for both populations as well as for total and rostered residents are below.

Mixed Population Model

A mixed model combines and weights the Fee-for-service and Capitated models to better reflect the primary care reform reality in Ontario for 2007 in which approximately 50% of patients are part of a primary care model where rostering of some type exists, and the other 50% of the population remains in the fee for service world.

For those patients in the fee for service primary care world, for each visit by a patient to a chiropractor, the chiropractor would receive a fixed amount ($20.00 in this case, to a maximum of $200.00). The patient pays a co-payment.

For those patients part of a primary care practice roster, each patient will be required to be assigned to a specific chiropractor for the year with the chiropractor receiving a capitation payment of $155 / patient and being committed to provide treatment for these individuals at a reduced co-payment rate of $20 per visit regardless of the number of visits.

Sessional Fee Model

Under this model each chiropractor could be paid on a salary basis for services provided to patients enrolled in existing primary care practices: Family Health Teams (FHT), Family Health Networks (FHN), Family Health Groups (FHG), Rural and Northern Physician Group Agreements 1&2 (RNPG), Community Health Centres (CHC),

Aboriginal Health Access Centres (AHAC), Health Service Organizations (HSO), the Group Health Centre - Sault St. Marie, and Primary Care Networks (PCN).

Primary Care Practices could contract for services with chiropractors based on the projected number of sessions required to service either their whole rostered patient population, or just the "vulnerable" populations. Session fees of $195 are derived from salary benchmarks established by the MoHLTC for Family Health Teams. Each session would provide for approximately 9 patient visits.

Conclusion

In Ontario, 11% of the general population uses chiropractic services. Less than 11% of the vulnerable populations use chiropractic services because of the out-of-pocket financial barrier yet the incidence and prevalence of back problems are greater among these segments of the population. Reinstatement of MoHLTC reimbursement for chiropractic services would be applauded by patients, chiropractors, family physicians and health system analysts. Furthermore, reinstatement is consistent with many of the Primary Health Care indicators developed by the Canadian Institute for Health Information (CIHI) which includes chiropractors within its list of primary care providers.

VULNERABLE POPULATIONS TABLES

The following tables provide a breakdown of the costs for vulnerable populations of each model in the categories of: Low Income, Seniors, Social Assistance.

Fee-for-service model

Fee for Service	**Maximum Exposure**	**Average**
Low Income	**$35.2 million**	**$28.2 milion**
Seniors	**$35.4 million**	**28.3 million**
Social Assistance	**$15.1 million**	**$12.1 million**

Capitation model

Capitation	**Ontario Rostered Vulnerable Populations Only**
Low Income	**$14.0 million**
Seniors	**$14.0 million**
Social Assistance	**$5.9 million**

Blended Model

Blended Model	**Total Ontario Vulnerable Populations**	**Total Ontario Rostered Vulnerable Populations Only**
Low Income	**$30.8 million**	**$15.8 million**
Seniors	**$31.0 million**	**$15.9 million**
Social Assistance	**$13.3 million**	**$6.8 million**

Mixed Population Model

Mixed Population Model	**Ontario Un rostered Vulnerable Populations Only**	**Ontario Rostered Vulnerable Populations Only**	**Total Vulnerable Populations**
Low Income	**$17.2 million**	**$14.0 million**	**$31.2 Million**
Seniors	**$17.3 million**	**$14.0 million**	**$31.3 Million**
Social Assistance	**$7.4 million**	**$5.9 million**	**$13.3 Million**
Total			**$75.9 Million**

Sessional Fee Model

Sessional Fee Model	**Ontario Rostered Vulnerable Populations Only**
Low Income	**$19.5 million**
Seniors	**$19.6 million**
Social Assistance	**$8.4 million**

FULL POPULATION SUMMARY TABLES

Fee for Service	**Total Ontario Population**	**Total Ontario Vulnerable Populations Only**
(All Residents) Maximum exposure	**$279.1 million**	**$85.7 million**
Estimated costs based on Average # visits	**$223.3 million**	**$68.6 million**

Capitation	**Total Ontario Rostered Population**	**Total Ontario Rostered Vulnerable Populations Only**
Estimated cost	**$110.3 million**	**$33.9 million**

Blended Model	**Total Ontario Population**	**Total Ontario Vulnerable Populations Only**	**Total Ontario Rostered Population**	**Total Ontario Rostered Vulnerable Populations Only**
Estimated Cost	**$244.2 million**	**$75.0 million**	**$124.6 million**	**$38.2 million**

Mixed Population Model	**Total Ontario Population (unrostered)**	**Total Ontario Vulnerable Populations Only (unrostered)**	**Total Ontario Rostered Population**	**Total Ontario Rostered Vulnerable Populations Only**	**Total Cost Total Populations**	**Total Cost Vulnerable Populations**
Estimated Cost: Capitation portion			**$110.3 million**	**$33.9 million**		
Estimated Cost: Fee for service portion	**$136.8 million**	**$42.0 million**				
Total Cost					**247.1 million**	**75.9 million**

Sessional Fee Model	**Total Ontario Rostered Population**	**Total Ontario Rostered Vulnerable Populations Only**
Estimated cost	**$154.2 million**	**$47.4 million**

INTRODUCTION

Musculoskeletal (MSK) pain is one of the leading causes of chronic health problems in people over 65 years of age. Studies suggest that a high prevalence of older adults suffer from MSK pain (65% to 80%) and back pain (36% to 40%).[1] In fact, according to a study by the Public Health Agency of Canada, back pain and migraines were 2 of the top 5 reasons that individuals reported visiting a physician.[2] Interestingly, the top three reasons that patients visit the chiropractor are back pain, neck pain and headache.

On December 1st 2004, the Ontario government de-listed chiropractic services from the basket of goods and services that it provides for vulnerable populations: "And despite the heroic efforts of the Ontario Chiropractic Association (OCA) and other organizations, the government remained steadfast in its decision, bringing an end to more than 30 years of public funding for chiropractic services in Ontario."[3] Prior to de-listing their services, the Ontario Health Insurance Plan (OHIP) paid $11.25 for an initial visit to a chiropractor and $9.65 for each subsequent visit up to a maximum of $150 per year. OHIP also paid for x-rays to a maximum of $40, which came out of the $150. (The $150.00 was reduced from $225 in 2002-03.)[4]

In September 2004 Deloitte Consulting services, on behalf of the Ontario Chiropractic Association, conducted a high-level analysis of the impact of the delisting of Chiropractic services. The final report clearly demonstrated that although delisting appeared to offer immediate cost savings, "there are far greater drawbacks that may impact the entire healthcare system in Ontario. The recent government announcement to de-list chiropractic services has potential implications on access to, cost of and quality of care for Ontario residents"[5].

There has been a shift in the type of patient that visits the chiropractor, and it is clear that seniors and other less advantaged patients are no longer visiting chiropractors in the same numbers. However, their illnesses and injuries are not disappearing. Patients are either no longer seeking care for their health problems, or are seeking care from health providers who fall within the scope of OHIP compensated services. Recent evidence demonstrates that those who are the most negatively affected by the de-listing of chiropractic services are the most vulnerable of Ontario's populations: the elderly (65+yrs), those with low incomes, and those on social assistance.

This paper sets out to provide funding options for consideration to provide chiropractic services to Ontario's seniors, working poor and those on social assistance.

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[1] C.J. D'Astolfo, B.K. Humphreys, "A Record Review of Reported Musculoskeletal Pain in an Ontario Long-Term Care Facility, BMC Geriatr. Vol. 6 No. 5, 2006.
[2] K.S. Iron, D.G. Manuel, J. William, "Using a Linked Data Set to Determine the Factors Associated with Utilization and Costs of Family Physician Services in Ontario: Effects of Self-Reported Chronic Conditions". Chronic Diseases in Canada, Vol. 24, No. 4, Public Health Agency of Canada (PHAC), 2003
[3] M. Devitt, "Delisting of Chiropractic in Ontario Takes Effect", Dynamic Chiropractic, Jan. 2005.
[4] Personal communication, Ontario Chiropractic Association
[5] Deloitte & Touche LLP, Ontario Chiropractic Association Impact of Delisting Chiropractic Services, 2004.

BACKGROUND

In February 2004, the Minister of Health and Long-Term Care announced the Ontario Government's agenda for restructuring and reform of the health care system with the aim of expanding care and treatment services in community-based settings and improving promotion and prevention efforts in order to reduce reliance on hospitals. Government priorities were revealed in the launch of 14 transformation projects which included Chronic Disease Prevention and Family Health Teams.

As part of the policy approval process that supported Family Health Team implementation, in June of the same year, Cabinet approved a list of interdisciplinary providers that could be included in the Family Health Team, including a reference to "other" health professionals.

In April of 2004, 150 Family Health Teams were announced across the province in both urban and rural settings. It is expected that these 150 teams will be operational by 2007/2008 and will improve access to primary care for more than 2.5 million Ontarians in 112 communities.

On July 14, the Minister announced the creation of Local Health Integration Networks (LHINs).

Moving forward, the Ministry may wish to contemplate a number of options for incorporating chiropractors and physiotherapists in FHTs such as: full integration (full team members as demonstrated by need), partial integration (direct referral or contracted service), or no integration

Furthermore, the government currently has not decided what funding options would be best for the reimbursement of services by "other health professionals". Options under consideration include salary, OHIP, payment per patient, co-payment or private payment. Compensation for chiropractors has become a more complicated issue than for other professionals in this group of providers.

If chiropractors are to be included in primary health care models, the MoHLTC will need to decide in what manner chiropractors will be included. Will they be full members of the team? If not, could physicians be provided with the names of all the chiropractors in their geographic area with whom they could work collaboratively?.

The lack of a clear decision related to funding for chiropractors within primary care reform represents an opportunity for the OCA to provide possible solutions.

IMPACT OF DE-LISTING SERVICES

The de-listing of chiropractic services from the basket of services funded by OHIP has negatively affected chiropractic patients by increasing the amount they are required to pay for a visit to a chiropractor.

It has also affected the chiropractors themselves. Many chiropractic patients who relied on the funding from OHIP no longer have access to this service, and chiropractors will need to replace lost resources due to this decrease in their roster of patients.

Prior to de-listing their services, the Ontario Health Insurance Plan (OHIP) paid $11.25 for an initial visit to a chiropractor and $9.65 for each subsequent visit up to a maximum of $150 per year. OHIP also paid for x-rays to a maximum of $40, which came out of the $150. According to the OCA recommended Service Codes and Fee Schedule, the 2006 fee that is recommended for "a common office visit" is $33.06. (Adjustments to this fee year-to-year reflect general inflation.)

Historically OHIP paid 80% of the cost of chiropractic services but in recent years this was reduced to a fraction (one third) of the chiropractic visit. This means that more affluent Ontarians have been able to absorb the extra $100-$150 per annum in fees. Others who have access to private insurance may not have felt the change (although there is anecdotal evidence that private insurers have also increased their deductible for chiropractic services in the past couple of years). Therefore it appears obvious that those who would most be negatively affected by the de-listing of chiropractic services by OHIP are the most vulnerable of Ontario's populations; those without private insurance: the elderly (65+yrs), those with low incomes, and those on social assistance.

The Ontario Chiropractic Association surveyed its membership and asked each chiropractor in Ontario to scan their files to determine how their patients and their fees have changed in the past two years. (Chiropractors were asked to provide patient information for two weeks in September 2004 and September 2006). Preliminary results are discussed below:

Fee Increases

In order to make up for the lost revenues from de-listing of their services, most chiropractors have been forced to increase the fee that they are charging their patients, effectively passing the direct cost of delisting their services on to the consumer. In other words, the majority of chiropractors increased their fees charged directly to patients between 2004 and 2006 by an average of only $3.00 but also had to pass along the $9.65 no longer covered by OHIP. Even so, chiropractor incomes have been virtually flat-lined for the period 2004-2006.

Decrease in Use by Vulnerable Populations

The overall number of patients seen by chiropractors decreased between 2004 and 2006[6]. The number of new patients declined 22% (this is particularly challenging for young chiropractors setting up new practices as well as for those contemplating careers in chiropractic). However, the number of patients visiting chiropractors who had extended health coverage increased by 40%[7], while the number of WSIB (Workplace Safety and Insurance Board) patients increased by 44%. The most significant difference in patient population lies in the number of MVA (motor vehicle accident) patients, which increased by 93% between 2004 and 2006. These figures indicate a significant shift in the demographic of patient visiting the chiropractor away from seniors, low income families and those on social assistance towards those with private insurance or funded by WSIB or automobile insurance claims.

This is most alarming as historically the socio-economic profile of the chiropractic patients was always slightly skewed towards the upper quintiles because of the co-payments.[8] With the delisting of chiropractic services the average chiropractor's socio-economic patient profile has become even more skewed towards the upper quintile because of the absolute financial barrier delisting has created for the most vulnerable in society. It has already been documented[9] that patients in Ontario with below average incomes are 55% more likely to forego care than the average income earner if faced with the deterrent of co-payment. Yet the prevalence of Neuromusculoskeletal (MSK) conditions and pain is highest amongst this group[10].

Frequency of Visits

A number of chiropractors indicated that patients have decreased the frequency of their visits as a result of delisting. This is borne out by the survey data which indicates a decrease in average visits/patient from 8.6 to 8.3.

[6] Figures based on a comparative sample practice audit of Ontario chiropractors for identical time periods in 2004 and 2006.
[7] Private insurance already represents 13% of the healthcare spending in Ontario – twice the OECD average. Delisting of chiropractic services has added to the privatization of Canadian healthcare.
[8] P. Manga, D. Angus, "Enhanced Chiropractic Coverage Under OHIP as a Means of Reducing Health Care Costs, Attaining Better Health Outcomes and Achieving Equitable Access to Health Services", February 1998.
[9] Commonwealth Fund International Health Policy Survey, 2004.
[10] P. Manga, D. Angus, February 1998.

Increase in Use of Hospitals and Family Physicians

According to Manga[11] one third of the visits to chiropractors will be substituted into the public health system. When considering the option of patients moving towards the fully funded publicly healthy system, consider the following factors:

- The total cost of visiting a physician including the physician's fees, diagnostic fees, and drug costs is virtually fully funded by the MoHLTC (adjusted cost per visit is estimated at $99[12]).
- The cost of visiting the emergency room (estimated at $143 per visit) is reflected in a hospital's global budget and also fully funded by OHIP;
- The severe family physician shortage in Ontario. Any movement of patients away from other health care providers towards this severely overburdened provider should be considered inappropriate at best;
- Patients in Ontario already experience long wait times for appointments to family physicians– in fact, the longest wait times amongst comparator countries[13]. The transfer of chiropractic patients to family physicians will only exacerbate this issue; and
- The increased level of inconvenience to the patient and decreased level of patient choice in the care they wish to receive.

At the time of writing, the physicians' claims database that would provide the data to more accurately estimate these shifts does not have current data available for the years 2005 and 2006. (Current data is only available for 2001/02 – 2003/04). However, a previous study concluded "…that enhanced OHIP coverage of chiropractic treatment could save Canada's health care system an estimated $380 million a year in direct costs, and up to $1.2 billion per year in indirect costs attributed to short and long-term disability."[14]

Delisting of chiropractic services was a form of cost-shifting but not just limited to the shifting of fees paid from government to the individual. Delisting also shifted short term reimbursement costs of simple treatment to become longer term costs of much more complicated and prolonged treatment. Recent published research showed that insured chiropractic services reduce average back pain episodes while reducing overall healthcare expenditures for diagnostics and hospitalizations[15]. Anticipated MoHLTC cost savings from delisting are artificial. Previous chiropractic costs have been shifted to other higher cost areas of the healthcare system and/or patients, especially for the most vulnerable who are delaying treatment thus exacerbating their medical conditions and eventual costs incurred by government[16].

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[11] P. Manga, The Fiscal and Health Care Effects of Ontario's Policy of De-Listing Chiropractic Care, University of Ottawa, 2004.
[12] Deloitte & Touche LLP, Impact of Delisting Chiropractic Services, 2004.
[13] Commonwealth Fund Primary Care and Health System Performance: Adults' Experience in Five Countries, 2004.
[14] P. Manga, D.E. Angus, February 1998.
[15] A.P. Legorreta, R.D. Metz, C.F. Nelson et.al., Comparative Analysis of Individuals with and without Chiropractic Coverage, *Arch Intern Med*, 2004: 164 (1985-1998).
[16] Deloitte & Touche LLP, 2004.

OTHER PROVINCES

A number of other provinces (British Columbia, Manitoba, New Brunswick) have special arrangements for vulnerable populations to allow them to access chiropractic services. The delisting of chiropractic services by the MoHLTC in Ontario which has negatively affected seniors, low income families, and those on social assistance is not congruent with government reimbursement policies, especially for vulnerable populations in other provinces (see Appendix 1).

ASSUMPTIONS FOR MODELS

The authors used all available hard data to generate this report; however, a number of assumptions were made to finalize the models. These assumptions included:

- According to the Ontario Ministry of Finance, the population of Ontario reached 12,686,952 residents on July 1, 2006[17].
- 11% of the population (1,395,565 Ontarians) visit a chiropractor annually[18].
- According to the Canadian Life and Health Insurance Association one third of Ontario residents do not have access to private insurance[19] (even though Ontarians rely upon private insurance more than twice the OECD average[20]).
- According to Statistics Canada[21], there are 1,608,700 seniors living in Ontario
- According to Ontario Social Assistance[22], in September 2006, there were 383,983 Ontarians living on social assistance through the Ontario Works program. There were a further 303,276 beneficiaries of the Ontario Disability Support Program. Thus, for the purpose of this report, the total number of Ontarians living on social assistance was 687,259.
- According to the Bank of Canada, the percent change in the Consumer Price Index (CPI) between 2004 and 2006 was 3.59% (indicating an average annual inflation rate of 1.78%).[23]
- The percentage of seniors in Ontario that are considered to be low income is 14.1%.[24] Given that the total number of seniors in Ontario is 1,608,700, then we will assume that the total number of low income seniors in Ontario is 226,827.
- According to a 2003 Statistics Canada report, 14.4% (1,826,921 individuals) of the total population in Ontario were considered to be low income before tax[25].
- According to the OCA recommended Service Codes and Fee Schedule, the 2006 fee that is recommended for "a common office visit" is $33.06[26]. (Adjustments to this fee year-to-year reflect general inflation.) For the purposes of this study, this amount will be used to denote the general cost of a chiropractic visit.
- According to Deloitte & Touche the average recipient of chiropractic care will visit a chiropractor 10 times each year[27].
- The three vulnerable populations of seniors, those receiving social assistance, and low income families were treated as one vulnerable population who now face significant financial barriers to chiropractic care

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[17] Ontario Demographic Quarterly, Ministry of Finance, Government of Ontario, September 27, 2006.
[18] Canadian Community Health Survey, 2000.
[19] Canadian Life and Health Insurance Association
[20] Canadian Institute for Health Information
[21] Statistics Canada.
[22] Ministry of Community and Social Services, Government of Ontario, Ontario Works: Quarterly Statistical Report.
[23] Bank of Canada Inflation Calculator
[24] Ontario Seniors' Secretariat, adapted from Statistics Canada, Income Statistics Division, A Portrait of Seniors in Canada, 1999
[25] Statistics Canada, Incidence of Low Income Among the Population Living in Private Households by Province, Jan. 10, 2005
[26] OCA Recommended Service Codes and Fee Schedule, January 1, 2006
[27] Deloitte & Touche LLP, Impact of Delisting Chiropractic Services, September 2004.

FUNDING OPTIONS

This paper explored five funding options:

- A fee-for-service model;
- A capitated model;
- A blended model;
- A mixed population model; and
- A sessional fee model.

The paper provides funding impacts for the whole population of Ontario as well as concentrating on those populations who have been most negatively affected by the decision to de-list chiropractic services, namely, seniors, low income earners and those on social assistance. The paper describes the possible impact of the funding options on patients, chiropractors and the health care system. The original research herein is not singular in its nature but builds upon research that has been previously performed.

Table I
Cost of providing Chiropractic Services to Ontario Population

Ontario Population	**# who visit a chiropractor** (11%)	**Total visits per year** (Average # visits/year=10)	**Visit Cost** (average patient cost per visit excluding x-rays)	**Total Cost**
Total Population: 12, 686,952	1,395,565	13,955,650	$33.06	**$461 million**
Seniors: 1,608,700	176,957	1,769,570	$33.06	**$59 million**
Low income: Total 1,826,921 – 226,827 low income seniors = 1,600,094	176,010	1,760,100	$33.06	**$58 million**
Social Assistance: Total 687,259	75,598	755,980	$33.06	**$25 million**
Total Vulnerable Population	428,565	4,285,650	$33.06	**$142 million**

The full financial impact of providing chiropractic care for all residents of Ontario is $461 million and for the three at-risk populations is $142 million. However, it is not expected that the MoHLTC would pay the full cost; this is unrealistic and unnecessary.

Fee For Service (FFS) Model:

This model assumes that for each visit by a patient to a chiropractor, the chiropractor will receive a fixed amount. Assumptions include:

- OCA recommended 2006 fee of $33.06.
- The fee paid by the Government of Ontario for a chiropractic visit prior to de-listing was approximately $10.00.
- In order to make chiropractic services more accessible to those vulnerable populations identified above, it is suggested that the MoHLTC pay for an increased proportion of each visit: $20 per visit,
- The MoHLTC will pay only for a maximum of 10 visits per patient per year, as this is the average number of visits that chiropractic patients require (maximum payment=$200/year).
- According to a study[28] by Waalen and Mior that examined the practice patterns of Ontario chiropractors, the mean number of chiropractic treatments per patient per year was 8.6, with a standard deviation of 3.4. The same study suggested that 34% of patients treated are in the 35 to 50 year range, and that the age group that uses the chiropractor the least are those residents over 65 years of age.
- It has been assumed that even though the vulnerable populations (of which older adults represent the lion's share) present more often with back problems, they do not access chiropractors any more frequently because of the co-payments. This is supported by data from the ICES Research Atlas, Chapter 2: *Arthritis and Related Conditions in Ontario.*[29]

The Ministry will have to decide whether they will pay the FFS for all residents of Ontario, or only for the most vulnerable populations. Impact calculations for both populations are below. As well, calculations have been made for a maximum number of visits to be paid by government and an average number of visits by each population.

[28] J.K. Waalen, S.A.Mior, Practice Patterns of 692 chiropractors (2000-2001) *J Can Chiropr Assoc* 2005; 49(1).
[29] Perruccio Ave, Badley EM, Guan J, ICES Research Atlas, Chapter 2: Arthritis and Related Conditions in Ontario, http://www.acreu.ca/pdf/ICES_atlas-ch2.pdf

Table II:
Costs of Fee for Service Model

Total Ontario Population *Maximum*	**Total Ontario Population** *Average*	**Vulnerable Populations Only** *Maximum*	**Vulnerable Populations Only** *Average*
Government Fee paid per visit: $20.00	Government Fee paid per visit: $20.00	Government Fee paid per visit: $20.00	Government Fee paid per visit: $20.00
# Residents visiting a chiropractor: 1,395,565	# Residents visiting a chiropractor: 1,395,565	# Residents visiting a chiropractor: 428,565	# Residents visiting a chiropractor: 428,565
Maximum # visits paid/year: 10	Average # of actual visits per year: 8	Maximum # visits paid/year: 10	Average # of actual visits per year: 8
Total # visits/year: 13,955,650	Total # visits/year: 11,164,520	Total # visits/year: 4,285,650	Total # visits/year: 3,428,520
Total MoHLTC cost: $279.1 million* ($20.00 x 13,955,650 visits/year)	**Total MoHLTC cost: $223.3 million** ($20.00 x 11,164,520 visits/year)	**Total MoHLTC cost: $85.7 million*** ($20.00 x 4,285,650, visits/year)	**Total MoHLTC cost: $68.6 million*** ($20.00 x 3,428,520 visits/year)

***** rounded to the nearest million

Advantages of this model:

- Chiropractors are paid for each visit. A 'clean' method of payment that provides payment only for care provided.
- Chiropractic services should become accessible again to many of the delisted patients.
- This is the model with which patients and providers are most familiar.
- OHIP will be offering significant assistance to those who have difficulty paying for chiropractic services as they will now be offering a subsidy of approximately 60% of the full cost of a visit.
- This model is easily incorporated into any type of practice (i.e. whether the chiropractor has a solo or group practice, works within a Family Health Team, etc.)
- The MoHLTC has a clear indication of the total *maximum* cost per year, as the yearly maximum is set. However, there is an opportunity for the MoHLTC to pay less.
- This model provides a yearly maximum amount of assisted care per patient equal to what was provided prior to delisting.

Disadvantages of this model:

- Some individuals may complain that they still find the cost of a chiropractic visit to be too expensive. (i.e. the remainder - approximately $13 - will need to be covered by the individual)
- Those individuals who require more than 10 visits per year will need to pay the full amount for a chiropractic visit once they have surpassed the OHIP limit. This may cause patients to ration their visits and may affect patient outcomes.
- As this system is based on a quota (based on an average) this formula approach does not take the individual patient and their specific needs into account.
- According to Mior (2006) the fee for service model "also provides a perverse incentive for patient care…tends to be provider driven, rewarding for provision of care rather than promoting patient self-care[30]"
- Furthermore, both the Romanow and Kirby Reports recommended not extending fee-or-service models.

In the past, the MoHLTC paid up to $150 per resident per year, which included up to $40 per year for x-rays. The model described above does not take into account payment for x-rays. Diagnostic x-rays should be taken in existing publicly funded institutions; public hospitals and Independent Health Facilities.

[30] S. Mior, J. Barnsley, H. Boor et.al., Chiropractic Primary Care Demonstration Projects: Implementing a Model of Interdisciplinary Collaborative Practice, August 2006.

Capitation Model:

Under this model each chiropractor will be paid a fixed amount by the Ministry of Health and Long-Term Care for each patient under their care. Each patient will be required to pay a co-payment for each visit to the chiropractor.

A capitated model for chiropractic services could function on the basis of eligible patients enrolled (or anticipated to be enrolled) in existing primary care practices: Family Health Teams (FHT), Family Health Networks (FHN), Family Health Groups (FHG), Rural and Northern Physician Group Agreements 1&2 (RNPG), Community Health Centres (CHC), Aboriginal Health Access Centres (AHAC), Health Service Organizations (HSO), the Group Health Centre - Sault St. Marie, and Primary Care Networks (PCN)

This study estimates that patient enrolment in all Ontario Primary Health Care (PHC) Models noted above as of February 2007 will be **6,492,399** patients (51% of Ontarians).

Assumptions:
1. That enrolled patient counts for FHNs, FHGs, RNPG1, RNPG2, HSO, GHC and PCN remain static for the period February 2006 to February 2007.
2. That enrolled patients by February 2007 for FHTs will reach 516,672 (see estimate, Appendix II)
3. That enrolled patients in CHCs, and AHACs will reach 400,000 by February 2007 (see estimate, Appendix II)

Prior to de-listing of chiropractic services, OHIP paid a maximum of $150.00 per patient per year. Adding inflation and cost of living increases for the past two years (3.59%) increases this number to $155.39. It is therefore assumed that the capitated amount per patient per year is fixed at $155.00.

In order to ensure that this model is equitable, chiropractors will have to keep track of the number of visits per patient and report this to the Ministry. This model can be re-assessed after a pilot period of two years, and adjustments made as required.

As with the fee-for-service model, the Ministry will have to decide if they provide this subsidy for all residents of Ontario, or simply for those who fall into the 'vulnerable populations' category. The calculations below are provided for all residents of Ontario, the vulnerable populations only, and also on a percentage basis calculated from the number of Ontarians expected to be able to take advantage of the primary health care models (i.e. 51%).

Table III:
Costs of Capitation Model

Total Ontario Population	**Rostered Total Ontario Population**	**Vulnerable Population Only**	**Rostered Vulnerable Population**
Government paid capitated amount: $155.00			
# Residents visiting a chiropractor: 1,395,565	# Residents visiting a chiropractor: 711,738	# Residents visiting a chiropractor: 428,565	# Residents visiting a chiropractor: 218,568
Total MoHLTC cost: $216.3 million * ($155.00 x 1,395,565 residents)	**Total MoHLTC cost: $110.3 million *** ($155.00 x 711,738 residents)	**Total MoHLTC cost: $66.4 million *** ($155.00 x 428,565 residents)	**Total MoHLTC cost: $33.9 million *** ($155.00 x 218,568 residents)
***** rounded to the nearest million			

Advantages of this Model:

- Possibly the easiest to implement for the MoHLTC from a reimbursement perspective.
- No restrictions on numbers of visits per year for the patient. (I.e. they get a reduced rate for the entire year, simply by being loyal to one chiropractor).
- This model will encourage patients to join family health teams, which is in line with MoHLTC objectives.
- If only patients that are part of primary health care reform are taken into account, this represents the least expensive model from the Ministry's perspective.

Disadvantages of this Model:

- ''Unusual" patients can severely skew compensation. Since this model is based on averages, it is the most likely to cause issues. (I.e. those who visit the chiropractor frequently will 'cost' the chiropractor. Alternatively, those patients who visit only once and never return will cost the MoHLTC.)
- This represents the most costly model of the three under discussion.
- Chiropractors may discourage individuals from returning as frequently as they should if they are only paid a set fee.
- Will patients be encouraged to sign up so that the chiropractor will get the capitated fee, even if their problem should not be addressed by chiropractic care?
- Will it prove to be difficult to 'keep track' of patients? I.e. if they sign up one year, how will the government prove that they are still current patients? How much of a grace period is given? I.e. if they do not visit their chiropractor in six months, are they no longer current patients of the physician?

Blended Model:

A blended model will provide the chiropractor with a set 'base' fee for every patient that signs on to their care. The chiropractor will additionally receive a set amount (lower than the usual fee for service) for each office visit.

Assumptions re Fees:
Base amount: $75.00 per year when the patient "signs up" with the chiropractor.
Fee per visit: $10.00 each time the patient visits the chiropractor (with no yearly maximum, however calculations will be made with averages of 10 visits per year.)

Once the patient has signed up, the chiropractor will submit their acceptance of the patient to the MoHLTC which will in turn send the base annual fee to the chiropractor's office. Each time the patient visits the office, the patient will be required to pay a co-payment of $15 for their visit. The chiropractor will then submit a record of each visit to the MoHLTC, and will be paid extra fee of $10.00 per visit.

As with the previous two models, the MoHLTC will have to decide whether they will pay for all residents of Ontario, or only for the most vulnerable populations. Impact calculations for both populations as well as for total and rostered residents are in Table IV.

Table IV:
Costs of Blended Model

Total Ontario Population	**Rostered Total Ontario Population**	**Vulnerable Populations**	**Rostered Vulnerable Populations**
Government paid capitated amount: $75.00			
Government Fee paid per visit: $10.00			
# Residents visiting a chiropractor: 1,395,565	# Rostered residents visiting a chiropractor: 711,738	# Residents visiting a chiropractor: 428, 565	# Rostered residents visiting a chiropractor: 218,568
Average # visits/year: 10			
Total # visits/year: 13,955,650	Total # visits/year: 7,117,380	Total # visits/year: 4,285,650	Total # visits/year: 2,185,680
Total MoHLTC cost: $244.2 million * ($75.00 x 1,395, 565 residents) + ($10.00 x 13,955,650 visits/year)	**Total MoHLTC cost: $124.6 million*** ($75.00 x 711,738 residents) + ($10.00 x 7,117,380 visits/year)	**Total MoHLTC cost: $75.0 million *** ($75.00 x 428,565 residents) + ($10.00 x 4,285,650 visits/year)	**Total MoHLTC cost: $38.3 million*** ($75.00 x 218,568 residents) + ($10.00 x 2,185,680 visits/year)
* rounded to the nearest million			

Advantages of this model:

- Possibly, this represents a more realistic compensation model compared to the capitated model.
- As the chiropractor receives $10 per patient per visit with no yearly maximum number of visits, “heavy use” patients will not skew payment as much as other models.

Disadvantages of this model:

- A complicated model that may cause confusion for patients.
- May be difficult and cumbersome from an administrative perspective.
- Patients may have difficulty paying the co-payment for chiropractic services (i.e. some may find even $15.00 per visit to be too expensive).
- If rostering is not taken into account, this represents the most expensive model from the Ministry's perspective.

Mixed Population Model

A mixed model combines and weights the FFS and capitated models to better reflect the primary care reform reality in Ontario for 2007 in which approximately 50% of patients are part of a primary care model where rostering of some type exists, and the other 50% of the population remains in the fee for service world.

Assumptions:

- As per the FFS model above, it is suggested that the MoHLTC pay for $20 per visit, representing a co-payment of approximately 60% the total cost of an average visit to the chiropractor.
- The MoHLTC will pay only for a maximum of 10 visits per patient per year, as this is the average number of visits that chiropractic patients require (maximum payment=$200/year).
- Prior to de-listing of chiropractic services, OHIP paid a maximum of $150.00 per patient per year. Adding inflation and cost of living increases for the past two years (3.59%) increases this number to $155.39. It is therefore assumed that the capitated amount per patient per year is fixed at $155.00.

For those patients in the fee for service primary care world, for each visit by a patient to a chiropractor, the chiropractor would receive a fixed amount ($20.00 in this case, to a maximum of $200.00). Patients would also be required to pay a co-payment.

For those patients part of a primary care practice roster, each patient will be required to be assigned to a specific chiropractor for the year. Once a patient is accepted to the chiropractor's care, the chiropractor will then be bound to provide treatment for this individual at a reduced rate (i.e. $20 per visit) for the entire year – even if this amounts to more than 10 visits. (If a patient requires more than 10 visits, they will have to continue to pay the reduced co-payment). However, if the patient requires less than 10 visits, the chiropractor will not be required to remit any funds to the MoHLTC. For each patient rostered to the chiropractor, the MoHLTC will pay the chiropractor $155.00

The following table outlines the costs to the MoHLTC for all residents and vulnerable residents.

Table V:
Costs of Mixed Population Model

Total Ontario Population Capitated (Rostered Population)	**Total Ontario Population Fee For Service (Un-rostered population)**	**Vulnerable Populations Only Capitated (Rostered population)**	**Vulnerable Populations Only Fee for Service (Un-rostered population)**
Government paid capitated amount: $155.00	Government Fee paid per visit: $20.00	Government paid capitated amount: $155.00	Government Fee paid per visit: $20.00
# Residents visiting a chiropractor: 711,738	# Residents visiting a chiropractor: 683,827	# Residents visiting a chiropractor: 218,568	# Residents visiting a chiropractor: 209,997
	Average # of visits per year: 10		Average # of visits per year: 10
	Total # visits/year: 6,838,270		Total # visits/year: 2,099,970
MoHLTC cost capitated portion: $110.3 million* ($155.00 x 711,738 residents)	**MoHLTC cost fee for service portion: $136.8 million** ($20.00 x 6,838,270 visits/year)	**MoHLTC cost capitated portion: $33.9million*** ($155.00 x 218,568 residents)	**MoHLTC cost fee for service portion: $42.0million*** ($20.00 x 2,099,997 visits/year)
Total MoHLTC cost: $247.1 million (capitated + fee for service totals)		**Total MoHLTC cost: $75.9 million** (capitated + fee for service totals)	
***** rounded to the nearest million			

Advantages of this model:

- May be the most realistic to implement given the current status of primary health care delivery in Ontario
- Provides options for patients based on their specific situation.
- Provides options for chiropractors and allows them access to alternative primary health care models, if they wish.

Disadvantages of this model:

- Different options for service delivery may be confusing for public.
- May cause more of an administrative burden, as two options for compensation are presented.
- Some patients may find the co-payment to be too high.

Sessional Fee Model

Under this model each chiropractor could be paid on a salary basis for services provided to patients enrolled in existing primary care practices: Family Health Teams (FHT), Family Health Networks (FHN), Family Health Groups (FHG), Rural and Northern Physician Group Agreements 1&2 (RNPG), Community Health Centres (CHC), Aboriginal Health Access Centres (AHAC), Health Service Organizations (HSO), the Group Health Centre - Sault St. Marie, and Primary Care Networks (PCN).

Primary Care Practices could contract for services with chiropractors based on the projected number of sessions required to service either their whole rostered patient population, or just the "vulnerable" populations. Session fees could be derived from a salary benchmark with adjustments for overhead costs, and benefits, and the average duration of a chiropractic session.

Funding for this model could be provided as part of the operational funding for primary care practices.

The average chiropractor works,(direct patient contact time for those working part- and full-time) about 37 hours per week [31]; takes four weeks vacation per year (this includes statutory and holiday days, sick days, etc.); and spends on average about 15 minutes per service, excluding time spent on related patient administration (64% of patients spend between 6 and 20 minutes per visit with a chiropractor)[32].

This study estimates that patient enrolment in all Ontario Primary Health Care (PHC) Models noted above as of February 2007 will be **6,492,399** patients (51% of Ontarians).

As part of the Family Health Team (FHT) implementation and planning process the Ministry of Health and Long-term Care set out the eligibility, approval, funding criteria, and guidelines for the compensation of non-physician interdisciplinary providers. The

[31] D. Galarneau, Health care professionals. Perspectives: Statistics Canada Catalogue no. 75-001 XIE. December 2003.
[32] I.D. Coulter, P.G. Shekelle, Chiropractic in North America. *J Manipulative Physiol Ther* 2005;28: 83-89.

Ministry determined that interdisciplinary team members of FHTs may be compensated through: salary, sessional funding, or contractual arrangement depending on the unique circumstances of the Family Health Team.

The salary benchmark for Chiropractors as an interdisciplinary health care provider in a Family Health Team[33] indicates that chiropractors can expect to earn between $54,000 and $78,000 per year, (not including other sources of income).[34]

In the case of FHTs, salary benchmarks for interdisciplinary team members were developed based on the assumption that the providers would be working in the facility provided by the FHT. However, considering that team members may be compensated through mechanisms such as sessional funding or contractual arrangements depending on unique circumstances, this study recognizes that such 'unique' circumstances will typically require a chiropractor to practice in an existing primary care facility, while also maintaining his/her own facility. In recognition of this fact, this study uses the high end of the salary range from the Family Health Team salary benchmark for Chiropractors to recognize some of the costs of overhead.

Assumptions:

1. A session is defined as one half day of chiropractic services provided through a primary care setting.
2. An average chiropractic visit lasts 22 minutes[35], with 15 minutes of direct patient time and an additional 7 minutes of related patient administration (new patient examination, new patient enrolment, consult and follow-up notes with primary care physician, scheduling etc.)
3. The funding for benefits will be limited to 20% of salaries[36]
4. For this study the salary of $78,000 will be used plus 20% in lieu of benefits for a annual salary of $93,600.
5. $93,600 / 48 weeks = $1,950/week. There are 10 - ½ days per week therefore a session fee = $195.00
6. A session could allow a chiropractor to see up to 9 patients. (3.5 hours per session, 22 minutes per patient visit).
7. That enrolled patient counts for FHNs, FHGs, RNPG1, RNPG2, HSO, GHC and PCN remain static for the period February 2006 to February 2007.
8. That enrolled patients by February 2007 for FHTs will reach 516,672 (see estimate, Appendix II)
9. That enrolled patients in CHCs, and AHACs will reach 400,000 by February 2007 (see estimate, Appendix II)
10. An average full-time Chiropractor works 48 weeks per year

[33] Guide to Interdisciplinary Provider Compensation in Family Health Teams, Ontario Ministry of Health and Long-Term Care, February 28, 2006
[34] All figures are expressed in dollars per annum, per FTE. Salaries are net of applicable benefits and overhead compensation; and based on an average of 40 hours a week. Part-time and sessional rates must be derived from the salary ranges provided above.
[35] Correspondence with the Ontario Chiropractic Association, December 19, 2006
[36] Guide to Interdisciplinary Provider Compensation in Family Health Teams, Ontario Ministry of Health and Long-Term Care, February 28, 2006

Table VI:
Costs of Sessional Fee Model

Rostered **Total Ontario Population**	**Rostered Vulnerable Populations**
Government paid session fee: $195	Government Fee paid per visit: $195
# Rostered residents visiting a chiropractor: 711,738	# Rosered vulnerable residents visiting a chiropractor: 218,568
Average # visits paid/year: 10	Average # visits paid/year: 10
Total # visits/year: 7,117,380	Total # visits/year: 2,185,680
Total required Sessions Per Year 7,117,380 visits/ 9 visits per session =790,820 sessions	Total required Sessions Per Year 2,185,680 visits/9 visits per session =242,853 sessions
Total MoHLTC cost: $154.2 Million ($195 x 790,820 sessions/year)	**Total MoHLTC cost: $47.4 Million** ($195 x 242,853 sessions/year)
***** rounded to the nearest million	

Advantages of this Model:

- Funding for this model could be provided as part of the operational funding for primary care practices allowing for maximum flexibility for meeting local community and practice needs
- Relatively easy to implement for the MoHLTC from a reimbursement perspective.
- Contracting services can be managed through individual primary care locations with the ability to increase or decrease service requirements periodically.
- This model will encourage patients to join family health teams, which is in line with MoHLTC objectives.
- This is the model has similarities to the Fee-for-service model in that it contemplates a patient co-payment with which patients and providers are most familiar.

Disadvantages of this Model:

- Some individuals may complain that they still find the cost of a chiropractic visit, related to co-payment, to be too expensive.

Summary Tables of the 5 Models' Total Ministry of Health and Long-Term Care Costs

Fee for Service	Total Ontario Population	Total Ontario Vulnerable Populations Only
(All Residents) Maximum exposure	**$279.1 million**	**$85.7 million**
Estimated costs based on Average # visits	**$223.3 million**	**$68.6 million**

Capitation	Total Ontario Rostered Population	Total Ontario Rostered Vulnerable Population Only
Estimated cost	**$110.3 million**	**$33.9 million**

Blended Model	Total Ontario Population	Total Ontario Vulnerable Populations Only	Total Ontario Rostered Population	Total Ontario Rostered Vulnerable Population Only
Estimated Cost	**$244.2 million**	**$75.0 million**	**$124.6 million**	**$38.2 million**

Mixed Population Model	**Total Ontario Population**	**Total Ontario Vulnerable Populations Only**	**Total Ontario Rostered Population**	**Total Ontario Rostered Vulnerable Population Only**	**Total Cost Total Population**	**Total Cost Vulnerable Population**
Estimated Cost: Capitation portion			**$110.3 million**	**$33.9 million**		
Estimated Cost: Fee for service portion	**$136.8 million**	**$42.0 million**				
Total Cost					**247.1 million**	**75.9 million**

Sessional Fee Model	**Total Ontario Rostered Population**	**Total Ontario Rostered Vulnerable Population Only**
Estimated cost	**$154.2 million**	**$47.4 million**

ANALYSIS AND DISCUSSION

There is no doubt that the services of chiropractors are sought and that chiropractors are considered to be valuable members of the health care system. The de-listing of their services from OHIP has had a negative impact on patients and the system as a whole.

One must ask the question of whether driving increased traffic towards family doctors makes sense in the current health environment in Ontario. According to the College of Physicians and Surgeons of Ontario: "The consensus among patients, physicians and policy-makers is that Ontario is facing a physician shortage of unprecedented proportions. The shortage of physicians and other health professionals is one of the most significant challenges facing our health care system today. Tens of thousands of Ontarians are at risk of not having timely access to physician services."[37]

If the Ministry of Health and Long-Term Care does resume partial payment for chiropractors' services, the move is likely to be universally applauded by:

- Patients will be provided a choice of providers and may once again be able to take advantage of chiropractors' services;
- Chiropractors who will once again be able to provide services for vulnerable populations who had not been able to afford their services; and
- Family physicians who will see an easing in their patient load as some patients will return to their chiropractors for their musculoskeletal care.
- Health system analysts.

Furthermore, reinstatement of MoHLTC reimbursement for chiropractic services would be consistent with many of the PHC indicators developed by the Canadian Institute for Health Information (CIHI) which includes chiropractors within its list of PHC providers. Such indicators include:

- Improving access to routine PHC
- Supporting programs for chronic conditions (such as MSK pain, about 2/3 of which is chronic)[38]
- Developing specialized programs for vulnerable populations
- Improving collaboration among health care providers

The recommendations in this report are designed to support the three priorities against which the Government of Ontario measures its own success at transforming healthcare:

- Reducing wait times
- Improving access
- Making Ontarians healthier.

[37] College of Physicians and Surgeons of Ontario, Tackling the Doctor Shortage: A Discussion Paper, May 2004.
[38] J.K. Waalen, S.A. Mior, *J Can Chiropr Assoc* 2005

APPENDIX 1

How does Ontario Funding for Chiropractic Services Compare?

Ontario

Prior to de-listing in December 2004, the Ontario Health Insurance Plan (OHIP) paid $11.25 for an initial visit to a chiropractor and $9.65 for each subsequent visit up to a maximum of $150 per year. (OHIP also paid for x-rays to a maximum of $40, which came out of the $150.)

Manitoba

Manitoba Health will insure a maximum of 12 visits per Manitoba resident per calendar year. The adjustment of the spinal column, pelvis and extremities are insured chiropractic services. In Manitoba once a patient has expired their 12 visits from Manitoba Health Services Commission (MHSC), social allowance recipients may have their Chiropractor apply through Family Services for additional blocks. The requests are reviewed by a panel of 3 Chiropractors (appointed by the Manitoba Chiropractors' Association) and granting is usually in blocks of up to 15 visits (all renewable). MHSC funding in 2006 was $10.25 per visit. The MCA is currently in negotiation with Family Services to develop a new structure to meet the needs of low income/social allowance recipients in the province.

New Brunswick

New Brunswick does not have any assistance except for individuals on social assistance; they may receive payment for travel to visit a chiropractor but no payment for the treatment.

British Columbia

The Medical Services Plan (MSP) of British Columbia insures medically required services provided by physicians and supplementary health care practitioners, laboratory services and diagnostic procedures.

In B.C., premiums are payable for MSP coverage and are based on family size and income. The monthly rates are:$54 for one person, $96 for a family of two $108 for a family of three or more. Assistance with the payment of premiums is available; regular premium assistance offers subsidies ranging from 20 to 100 per cent, based on an individual's net income (or a couple's combined net income). If the resulting amount referred to as "adjusted net income" is $28,000 or below, a subsidy is available.

The adjusted net income thresholds are:
$20,000 - 100 percent subsidy
$22,000 - 80 percent subsidy
$24,000 - 60 percent subsidy
$26,000 - 40 percent subsidy
$28,000 - 20 percent subsidy

MSP beneficiaries with premium assistance status qualify for MSP coverage of up to $23 per visit for physiotherapy, massage therapy, chiropractic, naturopathy and non-surgical podiatry services up to a combined maximum of 10 visits per patient per calendar year.

Alberta

Alberta partially covers chiropractic services through its provincial reimbursement plan. Alberta pays chiropractors $13.61 per visit with a $200 maximum allowed per person per year.

APPENDIX II

Enrolled Patients in Primary Care Models

		# of patients signed *	How patients join	Notes
1.	FHT	516,672	Sign enrolment form	Based on Estimate
2.	FHG	4,043,740	Sign enrolment form (optional)	
3	FHN	797,904	Sign enrolment form	
4.	NGFP Now RNPGA Grp 1	Approx. 70,000 (in progress – not yet able to enroll).	To date no joining process - new agreement has enrolment	
5.	CSC Now RNPGA Grp 2	Approx. 50,000 (in progress – not yet able to enrol).	To date no joining process - new agreement has enrolment	
6.	CHC	400,000	Plans for pt enrolment; Geographical or priority population catchment areas	Based on Estimate
7.	HSO	260,290	Sign enrolment form	
8.	GHC	59,172	Sign enrolment form	
9.	PCN	294,621	Sign enrolment form	

Sources: Claims History Database and Provincial Health Planning Database, Ministry of Health and Long-Term Care, Government of Ontario, 2006.

<u>FHT estimates for 2007</u>

Assumptions:

- As of Feb 2006 there were only 16 FHTs in pre-operational stages of development.
- The average patient roster per FHT is anticipated to be 16,667 in 2007/08.
- By 2007/2008 there are to be 150 FHTs operational in Ontario serving approx. 2.5 million people.

Estimate:

While current rostering numbers are not available, the HLI estimates that by Feb 2007 there will be 516,672 enrolled patients with FHTs in Ontario:

- 20 FHTs in full operation with 75% of its maximum patient load rostered (250,000)
- 40 FHTs in pre-operation stage with 40% of its maximum patient load rostered . (266,672)

CHC/AHAC estimate for February 2007

By 2008, once rolled out, no fewer than 550,000 Ontarians will be accessing primary health care in the province through a total of 103 CHCs and Satellite CHCs

Presentation by The Association of Ontario Health Centres (to the Legislative Assembly Standing Committee on Finance and Economic Affairs Regarding The Ontario Budget 2006/07
January 30, 2006

Currently, CHCs and AHACs serve 350,000 Ontarians—2.8 percent of the province's population—with base funding for CHCs from the Government of Ontario in 2004-05 of $154 million.

Presentation by The Association of Ontario Health Centres (AOHC) to The Honourable Greg Sorbara, Minister of Finance;
The Honourable George Smitherman, Minister of Health Long-Term Care; The Honourable David Caplan, Minister of Public Infrastructure Renewal
February 2005

Therefore it is estimated by this study that 400,000 patients will be accessing primary health care through CHCs and AHACs combined by February 2007.

WARD HEALTH STRATEGIES

Ward Health Strategies (WHS) offers clients strategic solutions to public policy issues affecting their health care businesses. We provide public affairs, government relations and health policy research and communications services that enable our clients to build strong relationships with government and to impact stakeholder attitudes and behaviors.

Ward Health Strategies prides itself on its solid understanding of policy development and its skills in finding solutions for complex issues that meet the needs of both our clients and those they seek to influence.

Our client service team, comprised of seasoned professionals with extensive government, health policy, advocacy, and public affairs experience, understand the political, legislative and regulatory processes and know how to reach key policymakers. We offer the reach and resources, hands-on strategic counsel, and the close partnership required to make the difference.

HEALTH LEADERSHIP INSTITUTE

The Health Leadership Institute (HLI) of the DeGroote School of Business is Canada's only executive education centre dedicated to the health industry. The HLI promotes innovative leadership while also providing health policy research, advisory services and patient advocacy.

The Founding Director of the HLI is Dr. D. Wayne Taylor who is an internationally recognized expert in the areas of strategic planning, health services management, total quality management and business-government relations. Named “Professor of the Year” a record five times at the DeGroote School of Business, Wayne has also worked as a consultant, corporate manager and public servant. He has over thirty years' of experience working with managers in long-term care, acute care, public health and health policy planning as well as the private sector.