

# **Payment Innovations for General Practice Physicians in Ontario, Canada**

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## Country Background Note: Canada (Ontario)

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February 2016

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This country background note was completed based on a template circulated to countries and experts involved in the OECD Project on Payment Systems. This completed template was used to inform the OECD Project on Payment Systems and was last updated in February 2016. It does not include policy changes that occurred since then. Authors are responsible for any error.

This country background note informs the publication *Better Ways to Pay for Health Care* available at: <http://www.oecd.org/health/better-ways-to-pay-for-health-care-9789264258211-en.htm>

## OECD Template for Case Studies of Innovative Payment Systems:

### Payment Innovations for General Practice Physicians in Ontario, Canada

<p>Short description of the new payment scheme</p>	<ul style="list-style-type: none"> <li>• <b>What is the new payment scheme/ reform? What are the objectives of this scheme? Which institutions/providers are targeted?</b>            In the late 1990s Ontario, Canada, inaugurated “Primary Care Reform” characterized by the sequential introduction of a menu of payment models replacing traditional fee-for-service for general practitioners. Key elements include:           <ul style="list-style-type: none"> <li>• Blended payment schemes employing various combinations of fee-for-service, capitation, incentives/bonuses (pay-for-performance), and/or salary</li> <li>• Patient enrolment (rostering)</li> <li>• Group requirement of three or more physicians for most models</li> <li>• Required provision of after-hours care for most models</li> <li>• Physician choice of payment model.</li> </ul>           Objectives include improved access, quality and continuity of care. In 1998, just under 100 percent of primary care physicians were paid by traditional fee-for-service and this had dropped to approximately 30 percent by 2013.         </li> </ul>
<p>Context and problem the reform aims to address</p>	<ul style="list-style-type: none"> <li>• <b>What problem(s) did the reform aim to address?</b> <ul style="list-style-type: none"> <li>○ At the onset of Primary Care Reform, the stated objectives were (Ontario Ministry of Health and Long-Term Care &amp; PriceWaterhouseCoopers, 2001):               <ul style="list-style-type: none"> <li>▪ Lack of communication and information sharing across the healthcare sector</li> <li>▪ Financial incentives for excess provision built into fee-for-service remuneration</li> <li>▪ Fragmentation of care as patients moved across the system</li> <li>▪ Uneven access to primary care</li> <li>▪ Increased number of “office only” primary care physicians.</li> </ul> </li> <li>○ Other key issues included reducing Emergency Department and in-patient admissions, preparing for the healthcare needs of an aging population, and making general practice medicine more attractive</li> </ul> </li> </ul>

	<p>as a specialty stream.</p> <ul style="list-style-type: none"> <li>○ Taking stock of the evolution of these models, primary care reform has become part of a broader effort to transform the health care system involving issues such as: faster access to care, better integrated scopes of practice for interdisciplinary practitioners, and an emphasis on the provision of comprehensive care including chronic disease management, health promotion and disease prevention.</li> <li>● <b>How was this problem identified and assessed? (quantitative data, opinions, etc....)</b> <ul style="list-style-type: none"> <li>○ Ontarians increasingly reporting not having a general practitioner</li> <li>○ Long wait times for care</li> <li>○ Increasing number of avoidable Emergency Department visits by patients that often could have received appropriate care in primary care settings</li> <li>○ Primary care medicine decreasingly perceived as a desired specialty among medical graduates (Ontario Medical Association, 2013).</li> <li>○ A combination of formal quantitative and qualitative information, as well as much popular discussion in the media, among various think tanks and advocacy groups, etc.</li> </ul> </li> <li>● <b>Who initiated the reform? What was the catalyst to make the payment reform possible? (e.g. political support)</b> <p>The Government of Ontario in partnership with the Ontario Medical Association (the latter represents the interests of physicians in the province and negotiates payment contracts/agreements on behalf of physicians).</p> </li> <li>● <b>Was payment reform the only way envisaged to address the problem?</b> <p>No, the reform was characterized by other key elements: formal patient rostering, after-hours service delivery requirements, and the requirement for all but one model of physicians to form groups. There was also a separate but mostly simultaneous increase in the flow of new physicians into the system through increasing medical school enrolment and immigration to address shortages and wait times.</p> </li> <li>● <b>Was the reform part of a larger set of policy reforms?</b> <p>Yes, the introduction of new physician payment models was integrated with many other primary care initiatives such as: primary care models and initiatives involving allied health professionals (e.g., the “Family Health Team” interdisciplinary model, expanded scopes of practice for selected allied health care providers, and Nurse Practitioner-led clinics); educational campaigns on when it is appropriate to go to an Emergency Department or when and where to seek urgent (but not emergent) care; educational campaigns on</p> </li> </ul>
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	<p>preventive care (e.g., diabetes management and colon cancer screening awareness) and initiatives aimed at helping Ontarians without a general practitioner find one (Health Care Connect program). More broadly, this primary care initiative has been integrated in the Government's larger goal of achieving patient-centred care aimed at improving quality, delivering faster access to care, and achieving local integration with other health care providers.</p>
<p>Understanding payment reform</p>	<ul style="list-style-type: none"> <li>• <a href="#">Which type(s) of provider does the new payment scheme target? (e.g. all hospitals, some hospitals [please specify], primary care centres, physicians, other professionals, public versus private settings, etc.)</a>        All primary care general practice physicians in Ontario. The models associated with these reforms are voluntary and physicians can join anytime. The most common models are the following (see Table 1 for more details).       <ul style="list-style-type: none"> <li>○ Family Health Group (FHG): Prevalent fee-for-service payment, a small rostering fee, after hours premiums, comprehensive care premiums for a select set of fee codes, and incentives and bonuses (pay-for-performance); group requirement, optional rostering.</li> <li>○ Comprehensive Care Model (CCM): Similar to FHGs, but for solo physicians (i.e., no group requirement).</li> <li>○ Family Health Organization (FHO): A prevalent capitation (about 70% of remuneration was from capitation in 2009/10) model that is blended on several dimensions. First, fee codes are divided into those inside a "capitated basket" and fee-for-service codes outside the basket. Second, fee codes inside the basket are again blended in that they also receive a 15% (formerly 10%) fee-for-service payment. Total fee-for-service billings are capped. Third, building on the capitated amount, there is an "Access Bonus" which is reduced as rostered patients see general practitioners outside the rostering physician's group. The fact that this is structured as a bonus that may be forfeited implies that there is a maximum penalty for patients seeing physicians outside their rostering group for capitated services. Fourth, layered on top of this are incentives and bonuses (pay-for-performance). Additionally, like FHGs, there is a small rostering fee, and after hours premiums.</li> <li>○ Family Health Network (FHN): Akin to the FHO model, but with a smaller capitated basket so that capitation represents just over 60% of total remuneration.</li> <li>○ Many other specialized models (there are 17 in total) were introduced to respond to characteristics of specific practices; the Rural and Northern Physician Group Agreement, for example, is a payment model designed for physicians practicing in rural and remote areas of the province and is characterized by a prevalent salary component.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Does the payment scheme target a specific patient group (e.g. a chronic condition, an age group, patients with complex need, all patients registered with a provider, general population)?</b> No, the scheme targets all primary care patients, including patients residing in long-term care facilities.</li> <li>• <b>Does the new payment scheme replace part or all of an existing payment method or is it an additional payment?</b> Almost all primary care physicians were paid traditional fee-for-service pre-reform, and some continue with this form of payment. Under the reform individual physicians are only enrolled in one model at a time (with flexibility for staffing Emergency Departments and the like) and they voluntarily select among the menu of payment models that has evolved over time. For individual physicians a (newer) payment model may replace traditional fee-for-service, but it may also replace another reformed model. At the system level, since selection into a payment model is voluntary with changes by physicians among various alternatives permissible (sometimes with delays) several payment models exist in parallel. In a small number of cases an existing payment model has been subsumed into a newer one, so overall the size of the menu has grown. Traditional fee-for-service remains an option; however, many general practitioners who continue to practice under this payment structure have “focussed” practices addressing areas such as sports medicine or psychotherapy.</li> <li>• <b>How was the level of the remuneration set? i.e. methods to determine the level of the remuneration and process to implement it (negotiation, unilateral decision)</b> Payment levels and rates are (mostly) determined through negotiations between the Government of Ontario and the Ontario Medical Association (OMA).</li> <li>• <b>Were outcome measures or indicators used (i.e. proxy measures of quality)?</b> Initially no formal outcome measures/indicators were employed to track the overall reform. More recently, some reporting requirements have been imposed on selected primary health care organizations (e.g. Community Health Centres, interdisciplinary Family Health Teams, Nurse Practitioner-led Clinics) to report yearly on specific indicators defined around the following quality dimensions: access, patient-centred care, integrated care and population health focus (Government of Ontario, 2014).</li> <li>• <b>If the payment scheme targets institutions or groups of providers, how is the remuneration shared between providers?</b> Each group of three or more primary care physicians is free to decide how to allocate payments (e.g., specific incentive payments) that are made to the group, but the bulk of the payments are physician-specific.</li> </ul>
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	<ul style="list-style-type: none"> <li>• <b>Was the new payment scheme supported by non-financial incentives?</b> No, although some may interpret some support surrounding IT and the like as non-financial despite the support typically taking the form of conditional transfers.</li> <li>• <b>If the payment scheme aimed to encourage cooperation between providers, were there explicit incentives for the providers and health professionals to support each other to meet the policy objectives? Were incentives aligned among providers to meet these objectives?</b> <ul style="list-style-type: none"> <li>○ Between physicians: many specific payment elements are designed to encourage cooperation between physicians in the same group and they are, indeed, aligned in such a way to enable this. For example, groups of physicians receive incentive payments, after-hours payments, and for capitated models an “access bonus” when patients who are enrolled with the group do not seek care from primary care physicians outside of the group.</li> <li>○ Between physicians and allied health care professionals, however, many incentives are not aligned in most models in that physicians receive incentives (e.g., preventive care bonuses) for services often provided by other health care providers who assist the group of physicians. The Family Health Team (FHT) program, an explicitly inter-professional add-on to two selected payment models, was introduced to encourage cooperation.</li> </ul> </li> <li>• <b>Where relevant: do all purchasers use this payment scheme or is it limited to specific payers (e.g. a specific insurer)?</b> Canadian health care is, within each province (with some exceptions such as members of the military), a universal single payer public system for residents, and this reform is universal in the province of Ontario. Note that in practice the “single payer” may be different arms of government, while the provincial Ministry of Health and Long-Term Care funds the vast majority of primary care, the Workers Safety and Insurance Board (commonly called Workers’ Compensation) and the federal government also fund a small share of it and have allied but somewhat different approaches to payment.</li> <li>• <b>Are there restrictions on how the providers can use the remuneration they receive?</b> No, with trivial exceptions such as very small conditional payments for Information Technology there are no restrictions.</li> <li>• <b>Is there a payment ceiling? What are the conditions?</b> There are two specific payment ceilings for the FHO and FHN models: <ul style="list-style-type: none"> <li>○ Maximum ceiling of FFS billings for capitated services provided to patients who are not enrolled with</li> </ul> </li> </ul>
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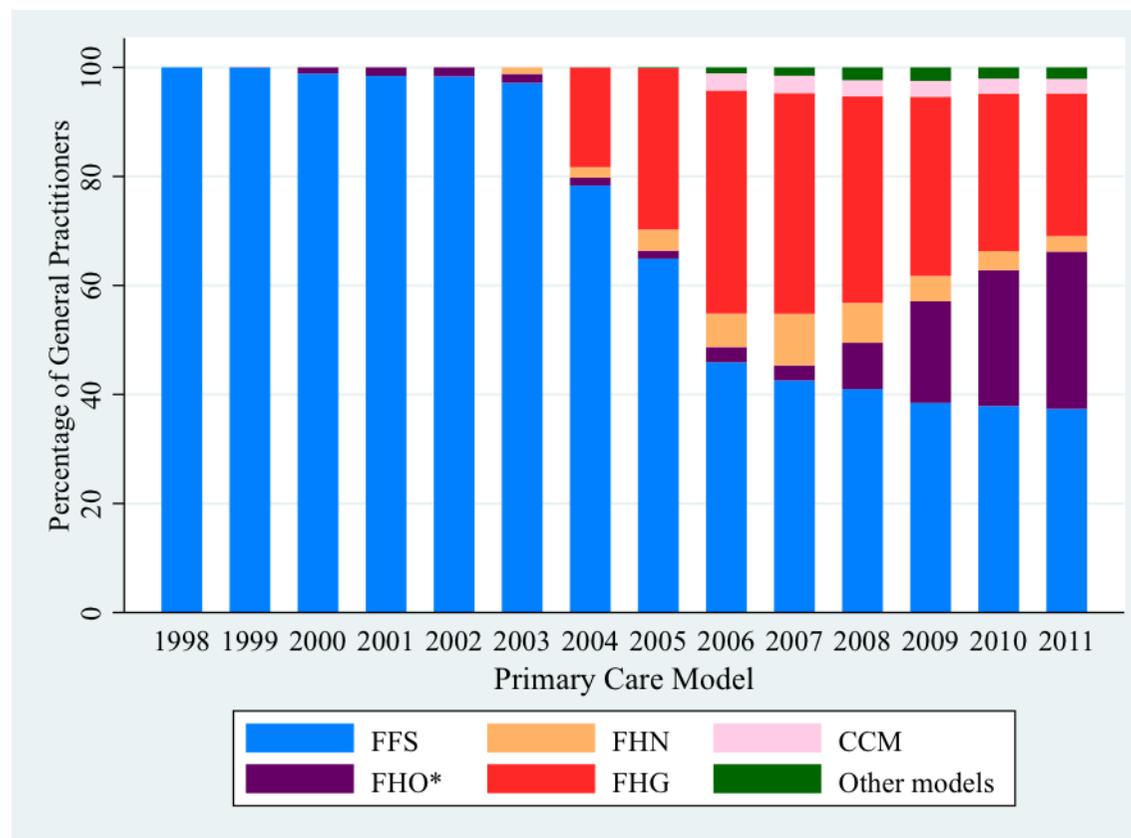
	<p>the group (approximately CAD \$56,000). This is not really a payment ceiling so much as a restriction on non-capitated billings for primary care physicians remunerated by capitation.</p> <ul style="list-style-type: none"> <li>○ A 50% reduction of the capitation payment if the average number of patients per physician in the group exceeds 2,400. (This is not a payment ceiling per se, but rather a financial penalty to having practices that are deemed “too large” for patients to be well served in a capitated setting.)</li> </ul> <ul style="list-style-type: none"> <li>● <b>Was evaluation embedded as part of the policy reform?</b> A formal program of evaluation was not embedded in the reform. Occasional evaluations were conducted: one in 2001 after the introduction of a pilot model (the Primary Care Network introduced in 1998), other internal evaluations were conducted. More recently the Auditor General of Ontario conducted an audit in 2011 (Office of the Auditor General of Ontario, 2011) and a follow-up in 2013 (Office of the Auditor General of Ontario, 2014). One of the Auditor General’s complaints was that evaluation had not been undertaken by the Ministry. Nevertheless, a limited number of evaluations of specific aspects of the reforms have been undertaken by various (mostly academic) researchers/evaluators (many funded by the Ministry) and some have likely been conducted internally by the Ministry.</li> <li>● <b>Was the policy scaled up if it was initially a pilot?</b> The first few pilots/models were capitation-based and, although they were made available to all physicians in the province, they saw very modest uptake until approximately 2004. See Figure 1 for uptake rates by model from 1998 to 2011. Beginning in 2004, a surge in reform model uptake is observed due to the introduction of the FHG model, “<i>this predominantly fee-for-service model propelled physicians into group practice</i>” (Fitzpatrick, 2010). In 2009, we observe a surge in the FHO model which successfully “<i>shifted physicians into capitated models as the predominant payment model</i>” (Fitzpatrick, 2010). Both the FHG and the FHO models were associated with appreciable increases in remuneration relative to traditional fee-for-service.</li> <li>● <b>Do certain aspects get revised/updated? If so, how frequently does it happen?</b> Yes, this program is constantly evolving. On the one hand, large scale changes such as new models (e.g., the FHO) and the inter-professional Family Health Teams (FHTs) have been introduced. On the other hand, iterative changes also occur regularly; some are of modest size, such as the elimination of the Telephone Health Advisory Service and preventive care contact payments, while others are smaller such as updating conditions for specific payment elements. Major updates and payment changes are made each time the Government of Ontario and the Ontario Medical Association negotiate a new contractual agreement which regulates payment for a defined period of time. For example, four-year agreements regulated payment in the 2000s (e.g., 2000, 2004, and 2008). However, the 2012 agreement was only a two-year agreement and</li> </ul>
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	<p>negotiations for a 2014 agreement failed in 2015 when the government imposed a series of cuts to physician payments.</p>
<p>Implementation of payment reform</p>	<ul style="list-style-type: none"> <li>• <b>Who initiated/proposed the reform?</b> The Government of Ontario's Ministry of Health and Long-Term Care in partnership with the Ontario Medical Association and other stakeholders.</li> <li>• <b>Which stakeholders were involved in the implementation strategy? (government, purchasers public/private, providers/provider associations, other independent associations, patients/advocacy groups)</b> Only the Government of Ontario who entered directly into agreements with (groups of) physicians.</li> <li>• <b>Has there been opposition to the payment reform from providers, purchasers or patient groups?</b> No major opposition has occurred as selection into the new models is voluntary and some new models are prevalently fee-for-service and hence close to what was the traditional method of payment. Also, the new models are associated with appreciable increases in total remuneration.</li> <li>• <b>If yes, how was it overcome? Was the policy implemented nationally or was it a pilot, or in a region, etc.?</b> Not applicable</li> <li>• <b>Was the participation voluntary and if so, what was take-up (number of providers or share in total of the target group)?</b> It was voluntary. See Figure 1 for trends in uptake. In 2013, the total population and the number of primary care physicians in the province were, respectively, 13.6 million and 12,000 (Ontario Physician Human Resource Data Centre, n.d.; Statistics Canada, n.d.). Note that some nominally primary care physicians in Ontario might not be classified as primary care by some definitions since they are effectively "GP-Specialists" focussing on mental health, sports medicine, or the like. Although licensed as primary care physicians, it is unlikely that they would join a model that requires a full range of primary care services to be offered. Hence 100% take-up is not expected.</li> <li>• <b>What was the timeline of payment reform? (abrupt change from one year to the next or was payment reform slowly phased in?)</b> Reform was introduced slowly with the first capitation-based model having been introduced in the 1970s. Models were always voluntary and, as mentioned above, saw a surge in 2004 with the introduction of the FHG model and in 2009 with the rising popularity of the FHO model (Government of Ontario, 2012). <i>"Neither evolution nor revolution is the appropriate metaphor. Rather, the gradual turning of a large ship onto a new course might be the preferable analogy"</i> (Sweetman &amp; Buckley, 2014).</li> </ul>

<p>Assessing payment reform</p>	<ul style="list-style-type: none"> <li>• Was the impact of the reform evaluated? Yes <ul style="list-style-type: none"> <li>○ What did the evaluation analyse? What type of evaluation was carried out (e.g. audit)? What information/data were used? Who carried out the evaluation? (e.g. commissioned, government, academic) <p>Although not an evaluation, the program underwent audit in 2011 (with follow-up in 2013) as part of the regular auditing process of the province’s Auditor General. Also, several evaluations of aspects of the reform were commissioned through the years or were conducted internally by the Government. Additionally, the scientific community has conducted studies looking at various trends and indicators pointing to mixed results. Several very credible evaluations have been conducted by employees of the Ontario Medical Association (OMA); in part, this credibility has been attained through academic publication (e.g., Kantarevic and Kralj, 2013).</p> </li> <li>○ Can providers contest or validate the results? <p>In general, there has been little public response outside of normal academic discussion. However, the OMA did take issue with some elements of the Auditor General’s report (e.g., Kralj &amp; Kantarevic, 2012).</p> </li> <li>○ After the evaluation was the policy revised? Discarded? <p>Elements of the reform have been modified in part in response to results from various evaluations. As mentioned above, the reform is constantly updated. The Government and the OMA usually work cooperatively and “a group of dedicated staff who worked hard internally to develop policy proposals for government” (Fitzpatrick, 2010).</p> </li> </ul> </li> <li>• Achievement of objectives <ul style="list-style-type: none"> <li>○ What are the results in terms achievement of target of policy objectives? (e.g. improvement in process of care, in outcomes for patients, savings, etc.). <ul style="list-style-type: none"> <li>▪ Success: in enrolling (rostering) patients with general practice physicians (approximately 10 million patients now enrolled in a population somewhat in excess of 13 million). However, it is not clear to what degree enrolment is actually changing practice patterns. Some commentators also attribute an increase in rates of finding a primary care physician for patients who did not have one to the reform – e.g., “500,000 more patients having a family physician in 2010 compared to 2007” (Office of the Auditor General of Ontario, 2011). However, it is not clear that this result follows from the reform or the concurrent but independent policy of increasing the physician to population ratio.</li> </ul> </li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>▪ Little change in: avoidable Emergency Department visits that could have received better care elsewhere, wait times to see a general practitioner are still high, and there are still notable challenges in providing care to the sickest patients.</li> </ul> </li> <li>○ <a href="#">How did providers respond to the payment reform? How did delivery of care change? Did the policy's incentives result in improved delivery of care?</a> Long-term outcomes: it is still largely unknown whether these new models are being successful in providing improved access in a more cost-effective manner. Similarly, it is unclear if there have been improvements in the quality or continuity of care as a result of these reforms.</li> <li>○ <a href="#">Was the administrative burden assessed?</a> No. However, the shift to capitation was viewed by some medical practices as reducing the need to submit bills to the Ministry. In contrast, the Ministry wished to track service delivery so a premium of 10% (later increased to 15%) of the fee-for-service rate was added for submitting claims for capitated services.</li> </ul> </li> <li>• <a href="#">Unintended consequences</a> <ul style="list-style-type: none"> <li>○ <a href="#">Did providers adopt behaviours to optimise payment received besides expected behaviour changes? (e.g. neglecting other activities, selecting patients, upcoding)</a> This is largely unknown; only one study seems to point to a relationship between capitation-based models and low cost patients (Rudoler, Laporte, Barnsley, Glazier, &amp; Deber, 2015). Further studies are underway.</li> <li>○ <a href="#">Did the new payment scheme generate positive spill over effects?</a> Unknown, although some academic evaluations are in process.</li> <li>○ <a href="#">Were there other unintended consequences? (e.g. patient behaviours, changes in providers market, etc.)</a> Unknown, there are currently joint Government of Ontario and OMA studies that are investigating some of these impacts (e.g., a study is underway to investigate Emergency Department use by capitated patients because Emergency Department visits are not considered outside use and hence do not reduce access bonus payments to capitated physician groups).</li> </ul> </li> <li>• <i>Other relevant comments:</i> This reform was very costly to the Government. Payments to general practitioners almost doubled from 1992 to 2009 (Fitzpatrick, 2010), which was far in excess of inflation. Also, it is important to highlight that these payments to physicians are their gross incomes out of which they must pay for office costs such as staff salaries, facilities costs, office supplies and equipment.</li> </ul>
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**Figure 1: Percentage of General Practitioners by Primary Care Model of Affiliation on March 31, 1998 to 2011**



\* Although the FHO model was introduced in 2006, preceding capitation-based models (i.e. Primary Care Networks — PCNs, and Health Services Organizations — HSOs) had been introduced earlier. PCNs and HSOs were discontinued in 2006 and automatically became FHOs.

Source: Authors' calculations based on data received from the Ontario Ministry of Health and Long-Term Care.

**Table 1: Basic Information on Selected Current Ontario Primary Care Models**

	<b>Traditional Fee-for-service — FFS</b>	<b>Comprehensive Care Model — CCM</b>	<b>Family Health Group — FHG</b>	<b>Family Health Network — FHN</b>	<b>Family Health Organization — FHO</b>	<b>Rural and Northern Physician Group Agreement — RNPGA</b>
<b>Primary method of remuneration (approximate average % of total physician income)</b>	Fee-for-service: 90+%	Fee-for-service: 75%	Fee-for-service: 80%	Capitation: 65%	Capitation: 70-80%	Base remuneration (salary): 75%
<b>Year of introduction</b>	1966	2005	2003	2001	2006*	2004*
<b>Percentage of general practitioners in this model in 2011</b>	37%	3%	26%	3%	29%	1%
<b>Group requirement</b>	No	No	Yes, minimum of three	Yes, minimum of three	Yes, minimum of three	Yes, minimum of three

\* The FHO and RNPGA models were preceded by other capitation or salaried models introduced in the 1970s and in the 1990s. When the FHO and RNPGA models were introduced respectively in 2006 and 2004, the preceding models were automatically discontinued and all existing groups converted to the new models.

**Acknowledgement:** This work was funded by the Government of Ontario, Canada through a Ministry of Health and Long-Term Care Health System Research Fund grant entitled 'Harnessing Evidence and Values for Health System Excellence'. The views expressed in this case study are the views of the authors and should not be taken to represent the views of the Government of Ontario.

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