Article details: 2019-0189	
Title	Fees for uninsured services: a survey of Ontario family physicians
Authors	Jamie R. Daw PhD, Kaitlyn E. Rice BA, Danyaal Raza MD MPH
Reviewer 1	Dr. Richard Lewanczuk
Institution	Endocrinology, University of Alberta, Edmonton, Alta.
General comments (author response in bold)	This is a fairly rudimentary descriptive study. My comments are as follows. 1. I find the rationale for this study very weak. There is no clear research question. Is it to find out the proportion or prevalence of physicians charging block fees? **To bolster the rationale for the study, we added citations to a number of newspaper articles and physician commentaries (including in CMAJ) that highlight both patient and physician concerns about block fees. Based on our informal discussions with family physicians in Ontario, the issue of fees for uninsured administrative services is considered a hot topic but one that has not received any attention from the research community. Even basic information on the prevalence of fees is a black box. As noted in this CMAJ commentary, "The College of Family Physicians and Surgeons of Canada…has "no idea" how many doctors across the country are now collecting annual fees" http://www.cmaj.ca/content/183/7/781.short Part of the reason is that this information is very difficult to collect, hence the need for a telephone study like ours.** **We clarified the objective in the introduction, see page 4: "The objective of this study was to estimate the proportion of family physicians who engage in different fee structures for uninsured services (i.e. à la carte, annual fees, or no charges) and to document variation in fee structures by geography and payment model."** I am not convinced this data would have an impact on uninsured services. The reader would likely be interested in why extra fees are charged and what those fees might be for "a la carte", whereas only block charges are addressed. **We agree that this study suggests that many other questions related to block fees should be explored. We believe there is value in first documenting the extent to which these fees are used to inform whether more research would be useful. We have revised the Interpretation section to more clearly outline topics and questions for future investigation.** **As researchers, we determined that a telephone survey was the most feasible (if not the only) way to collect information on fees from physicians. However, this mode limited the number of details that we**

	could ask. As we describe in our response to point #6, when we piloted the telephone survey, we found that receptionists were not willing to spend more than 60 to 90 seconds on the phone with the research assistant. These are very busy offices and it would not have been feasible to collect detailed information on all a la carte services for which fees are charged and the corresponding amounts. We hope that our study will prompt more data collection and research on this topic. Not sure how this applies outside of Ontario and hence interest for a general Canadian readership. **We added more detail related to fees for uninsured services across provinces, including citations to regulatory guidance documents from each province and a table that includes recommended fees in different provinces for a select set of uninsured services.** **We focused on Ontario because it is the location of many of the media reports and commentaries about fees for uninsured services, and thus we believed would be an appropriate jurisdiction to begin to study the prevalence of these fees. However, we note on page 8 that these results may not generalize across the country: "Fourth, the findings of this study may not be generalizable to other provinces; more research is needed to explore variation in uninsured fee practices across Canada."** 2. How was the sample size of 275 determined? With a final number of 166, and divided by geography and income source, how confident are the authors in having representative groups? **The sample size was chosen based on resource constraints and feasibility. We believe that the confidence intervals are reasonably precise for this study. We added sentences about the margin of error for sample estimates based on the final sample size on page 5: Assuming the most conservative population prevalence of 50%, the sample size of 166 physicians allows us to estimate the proportion of uninsured fee use with a margin of error of 7.6%. Assuming a standard deviation of $100, this sample size allows us to estimate the mean block fee rate with a margin of error of $15.** **To assess the representativeness of the sample, we now provide statistics comparing our sample characteristics to statistics on all family physicians in Ontario on page 6: The geographic characteristics of this sample are consistent with other descriptive data on Ontario's primary care workforce: a 2013 analysis found that 9.3% of general practice and family physicians work in rural areas of the province.(22) However, our sample had a lower proportion of capitation-based payment than other reports. An analysis of Ontario physician compensation from 2015-2016 reported that 38% of family physicians were enrolled in a capitation-based payment model.(23)** 3. Was there any validation of rates (for block funding) or is the data purely based on reported values? Similarly was there any other validation of data (e.g. confirming those who said they didn't charge, actually

	didn't)? **This is an important point. We've added a note on page 8 noting that there are no other sources of data available to validate our responses: Second, there is no available source of data to validate whether (and how often) individual physicians actually charge fees to their patients. It is possible that relatively few patients are actually charged à la carte fees, or that few patients opt-in to the annual block fee when it is offered.** 4. The paragraph beginning at the end of page 7 - on line 150 - is highly speculative. There should be some supporting evidence (references) for such suppositions. **Thanks for this note. We removed the paragraph.** 5. The figures are redundant with the tables. **Thanks for this suggestion, we moved Tables 1 and 2 to the appendix. We still include the tables in the appendix so readers have access to the exact point estimates and confidence intervals in the figure.** 6. There are many aspects which the readers would have been interested in such as charges for a la carte services, the type of a la carte services charged for vs not charged, reasons for the urban-rural differences, etcetera. I would suggest that the authors might want to consider a more fulsome paper to address some of these issues. **We absolutely agree that there are many issues that need to be further explored. We hope that this study provides the rationale for ourselves (and other researchers) to further investigate these issues. Many of these questions will require significant research funding to be feasible; for example, understanding the reasons for urban rural differences would likely require qualitative interviews with physicians.**
Reviewer 2	Dr. Maude Laberge
Institution	Department of Operations and Decision Systems, Faculte des sciences de l'administration, Universite Laval, Quebec, Que.
General comments (author response in bold)	The study examines user fees for uninsured services with a cross-sectional survey of family physicians in Canada. Introduction: 1. Background and the literature on uninsured services provided by family physicians is a bit slim. I am not

	familiar with that literature in Ontario but I know that these fees have been a health policy hot topic in at least one province for the past few years. The issue was addressed with legislation about what physicians can charge for and amounts allowed. **We added more detail to the introduction on fees for uninsured services across provinces, including citations to regulatory guidance documents from each province and a table that includes recommended fees in different provinces for a select set of uninsured services.** **To our knowledge, the only province that has introduced legislation related to patient fees is Quebec. This 2017 legislation was focused on "accessory fees" for supplies or medications used during a covered service such as drugs or anesthesia. It did not restrict fees or the amounts charged for uninsured services or what RAMQ refers to as "administrative fees" (the focus of our study). As stated in the RAMQ guidance, physicians are permitted to bill for any administrative procedure requested by the patient whether related to an uninsured service or not (e.g. form completion for third parties such as insurers or employers, prescription renewals, medical records for a third party).** **http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/citoyens/en/autres/FAQ_costs_billed.pdf#page13** **However, under the 2007 Health Insurance Act, physicians must post a public list of fees for uninsured services in their offices and provide patients with a detailed bill when fees are charged. We have added a note to this effect on page 3: "One exception is in Quebec, where physicians are required under the 2007 Health Insurance Act to post fees for uninsured services in public view and to provide patients with detailed invoices for any fees charged"** 2. The value of the study needs to be clarified. I have difficulty seeing its importance in contrast to other questions: How are patients affected by user fees? Have fees affected patients' access to services and experience with care? How so? **We absolutely agree that these questions should be a priority for research. However, we believe there is value in first establishing the baseline prevalence of these fees to help make the case that further investigation is warranted.** **We had originally proposed posing as patients during the telephone calls to gauge how the fees are presented to patients, however, this approach was not permitted by the Institutional Review Board. Thus, we were limited to asking questions from the perspective of university researchers.** Methods 3. It is not clear how the number of physicians to be contacted was determined. Why 275? And if this was based on a power calculation, did it account for a rate of non-response? **The sample size was chosen based on resource constraints and feasibility. We believe that the**

	confidence intervals are reasonably precise for this study. We added sentences about the margin of error for sample estimates based on the final sample size on page 5: Assuming the most conservative population prevalence of 50%, the sample size of 166 physicians allows us to estimate the proportion of uninsured fee use with a margin of error of 7.6%. Assuming a standard deviation of $100, this sample size allows us to estimate the mean block fee rate with a margin of error of $15. 4. Did the authors compare respondents from the total population to assess how representative the sample was? **To assess the representativeness of the sample, we now provide statistics comparing our sample characteristics to statistics on all family physicians in Ontario on page 6: The geographic characteristics of this sample are consistent with other descriptive data on Ontario's primary care workforce: a 2013 analysis found that 9.3% of general practice and family physicians work in rural areas of the province.(22) However, our sample had a lower proportion of capitation-based payment than other reports. An analysis of Ontario physician compensation from 2015-2016 reported that 38% of family physicians were enrolled in a capitation-based payment model.(23)** 5. What was the rationale for excluding walk-in clinics? **We added an explanation for this exclusion on page 5: "We also excluded physicians whose primary practice was a walk-in clinic because these physicians are likely to have a less stable patient population, and thus may have a lower propensity to charge annual fees for uninsured services."** 6. I wonder why the ethics was requested from an American institution and not in Ontario, given that the participants were in Ontario. What is acceptable from the REB in the US may not be in Ontario (and vice-versa). Since one of the authors is based in Ontario, why was ethics not obtained from an institution that this author is affiliated with? **The IRB at Columbia University investigated this issue and concluded that review at a Canadian institution was not required. This is because Canada and the U.S. both follow an institutional model for research ethics review where the institutions that conduct the research are responsible for its review (as opposed to a regional model, common in Europe, which is responsible for review over a particular geographic area).** **The co-investigator based in Ontario was not involved in any aspects of data collection or analysis and thus IRB approval from their institution was not required.** 7. Interpretation

	8. There is some missing link to the literature from Canada on patient user fees. Although scientific literature may be limited, this is a topic on which there is substantial grey literature that ought to be considered when undertaking such a study. **We have searched extensively and are not aware of any grey literature on fees for uninsured services, apart from newspaper articles, commentaries in medical journals and reports/guidance from medical professional associations (to which we have added several citations).** **While there is a wide literature on patient fees for medical services (e.g. copayments) and their impact on access to care, it is not clear that making an analogy to cost-sharing for medical care is appropriate. We would certainly welcome specific citations from the reviewer.**
Reviewer 3	Dr. N Nante
Institution	Department of Experimental Medicine and Public Health, Università di Siena, of Physiopathology, Siena, Italy
General comments (author response in bold)	Does the background accurately represent current knowledge in this field? The introduction section should be expanded. It not accurately represents current knowledge in this field. It is not enough detailed and it mentions only one article. It is reported that an increasing number of family doctors in Ontario are opting to charge annual block fees; the authors should include bibliographic citations in support of this statement. Moreover, in the introductory section, the Canadian legislative framework is well described, but there are no legislative references. References should be added and the benefits covered by public insurance and the benefits not covered should be specified. In addition, the benefits included in the block tax should be specified. **We added legislative references to the Canada Health Act and the Quebec Health Insurance Act. We also added citations to newspaper articles, physician commentaries, and regulatory guidance documents from each province. We also added a Table including examples of some uninsured services and the recommended fees in different provinces. The benefits in the block tax generally include all uninsured administrative services provided by a physician as stated on page 1: "annual "block fee" that covers all uninsured administrative services for a patient or family for one year."** In my opinion, the specific Canadian situation should be further explained by mentioning articles that have addressed similar issues, but I recommend authors to also refer to foreign countries to see the various ways of organizing with pros and cons. As regards the consequences not investigated for patients, and expressed as a limit of the research, also in order to increase the international bibliographic citations, I suggest reading these articles: - Quercioli C., Messina G., Basu S., McKee M., Nante N., Stuckler D. The effect of public-sector health

	care delivery on avoidable mortality: longitudinal cross-regional results from Italy, 1993-2003 Journal of Epidemilogy and Community Health, 132-138, 201". - Quercioli C., Messina G., Barbini E., Carriero G., Fanì M., Nante N. Importance of sociodemographic and morbidity aspects in measuring health-related quality of life:performances of three tools The European J. Health Economics, 389-398, 2009. - Golinelli D., Toscano F., Bucci A., Lenzi J., Fantini M.P., Nante N., Messina G. Health Expenditure and All-Cause Mortality in the 'Galaxy' of Italian Regional Healthcare Systems: A 15-Year Panel Data Analysis. Applied Health Economics and Health Policy, 1-11, 2017 **We are not certain how the citations provided relate to the topic at hand. We were not able to find published research articles on the use of administrative fees for physicians in other countries.** • Do the authors explain why they conducted the study? The authors give a sufficient explanation of the purpose of the study, even if they do not mention a future use of the results of the study. • Is there a clear research question? Yes, the aim of the research is well described. • Is the study design appropriate? The study design is appropriate. • Are the methods described in enough detail? Did you find anything confusing? You may wish to consider: participants, intervention, exposure, comparator, outcome, confounders, bias. The sampling technique should be better explained. It is not clear which method was chosen to calculate the sample size. Is the final sample of 166 general practitioners representative of the population surveyed? Why does the random sample include only 275 physicians? They should explain the reason for this choice. **The sample size was chosen based on resource constraints and feasibility. We believe that the confidence intervals are reasonably precise for this study. We added sentences about the margin of error for sample estimates based on the final sample size on page 5: Assuming the most conservative population prevalence of 50%, the sample size of 166 physicians allows us to estimate the proportion of uninsured fee use with a margin of error of 7.6%. Assuming a standard deviation of $100, this sample size allows us to estimate the mean block fee rate with a margin of error of $15.** **To assess the representativeness of the sample, we now provide statistics comparing our sample**

	characteristics to statistics on all family physicians in Ontario on page 6: The geographic characteristics of this sample are consistent with other descriptive data on Ontario's primary care workforce: a 2013 analysis found that 9.3% of general practice and family physicians work in rural areas of the province.(22) However, our sample had a lower proportion of capitation-based payment than other reports. An analysis of Ontario physician compensation from 2015-2016 reported that 38% of family physicians were enrolled in a capitation-based payment model.(23) • Are the results reasonable? Interesting? Surprising? The results are reasonable and make it possible to understand the different types of economic relationships proposed by Canadian physician's. • Is the interpretation supported by data in the results? Yes, the interpretation section is supported by data in the results. • Do tables and figures accurately represent the data? Would some other visual be more helpful? The graphs and tables are simple and clearly interpretable. • Are any important limitations not mentioned? The limits are mentioned in the study. • Did you spot any fatal flaws? That is, errors you do not believe the authors could overcome. Please explain clearly. I don't spot any fatal flaws. • For whom are these findings relevant? These data are important both from an economic and organizational point of view for those involved in health planning. • Do the authors place their findings in the context of the literature? Not at all. It is really important to expand this field. **We have searched extensively and are not aware of any grey literature on fees for uninsured services,**

	apart from some newspaper articles, commentaries in medical journals and reports/guidance from medical professional associations (to which we have added several citations). **While there is a wide literature on patient fees for medical services (e.g. copayments) and their impact on access to care, it is not clear that making an analogy to cost-sharing for medical care is appropriate. We would certainly welcome specific citations from the reviewer.**
Reviewer 4	Dr. Raisa Berlin Deber
Institution	Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ont.
General comments (author response in bold)	The authors seek to clarify how fees are charged by Ontario family physicians for uninsured services. In the abstract, they say they performed a cross-sectional telephone study of a random sample of 275 family physicians, but the paper clarifies that this is from a potential sample size of 16,189 physicians licensed to practice in Ontario, and that they reduced the sample to 211, and received responses from 166 physicians. I would therefore recommend that the abstract methods indicate that it was a random sample of 166 physicians. **Thanks for this note. We changed the sample size to 166 in the abstract.** The paper seeks to understand "the prevalence of fees in primary care", but defines this in terms of what proportion of the physicians they interviewed charge such fees, as opposed to what proportion of patients are charged them. Most would not define prevalence in this way, and the results can accordingly be misleading. The paper does not include any data on how many patients are charged, and what proportion of services/billings these account for. Indeed, the telephone script given in Appendix A indicates that they did not ask what the non-block fees were, and how many paid them; neither did they ask about how many of their patients paid block fees. As such, they're asking (and answering) a much narrower question about what payment models are used by those physicians that do charge such fees, with no sense of how many of their patients are affected. **This is an important point. We agree that there are two relevant estimates of interest: (1) the prevalence of use of fees by physicians; and (2) the prevalence of fees paid by patients. We believe that both are important, and the study addresses the former.** **We clarified the objective of the study to make our focus clear. See page 4: "Given this lack of data, no study has examined the prevalence of physician use of fees for uninsured services in any Canadian province. The objective of this study was to estimate the proportion of family physicians who engage in different fee structures for uninsured services (i.e. à la carte, annual block fees, or no charges) and to document variation in fee structures by geography and payment model."** **All physicians who use an annual block fee are supposed to send out a written letter to their patients**

	about this option. We added a back-of-the-envelope estimate for the number of patients in Ontario who may be receiving this letter: "Given estimates of 13,340 primary care physicians (based on 2015/16 data) and a mean primary care practice size of 1888 (based on 2010/2011 data), approximately 5 million patients in Ontario could be receiving letters from their family physician about annual block fees each year.(25,26)" **We also added a note on page 8 noting that there are no other sources of data available to confirm how many patients actually pay these fees: Second, there is no available source of data to validate whether (and how often) individual physicians actually charge fees to their patients. It is possible that relatively few patients are actually charged à la carte fees, or that few patients opt-in to the annual block fee when it is offered.** **We agree that this study suggests that many other questions related to block fees should be explored, including the prevalence of fees paid by patients and their experiences with those fees. We added several suggestions for further investigation in the Interpretation.** **In terms of the limited information collected, we determined that a telephone survey was the most feasible (if not the only) way to collect information about fees from physicians. However, this mode limited the number of details that we could ask. When we piloted the telephone survey, we found that receptionists were not willing to spend more than 60 to 90 seconds on the phone with the research assistant. These are very busy offices and it would not have been feasible to collect detailed information on all a la carte services for which fees are charged and the corresponding amounts. However, we hope that our study will prompt more data collection and research on this topic. We added suggestions about how this data could be collected on page 10: "To assist further investigation of patient fees, professional bodies and/or provincial governments could require physicians to report uninsured fee schedules and/or provide copies of patient letters regarding annual block fees. A public reporting mechanism could also be established. This data would assist with monitoring of compliance with regulatory college policies and inform the need for, and development of, further physician guidance and enforcement mechanisms."** Since the CIHI data says that over 98% of expenditures for physician services in Canada are publicly funded, it seems unlikely that these payments for uninsured services account for a significant proportion of services provided by Ontario family physicians. **Another important point. We added a reference to this fact in the Interpretation. We also point out that the size of the average annual block fees is relatively large compared to average per-capita OOP health expenditures in Canada. See page 9: "The total sum of payments for uninsured services is likely small: all out-of-pocket expenditures for physician services comprised only 1.7% of total physician**

	expenditures in Canada in 2016.(27) However, the average individual block fee of $106 is relatively large when compared to per-capita out-of-pocket spending on prescription drugs ($188 in 2018) and total per-capita out-of-pocket health spending ($972 in 2016).(27,28)" The paper does mention how much tends to be charged for those using annual block fees, but does not indicate how large the fees are that are charged a la carte, and how well these agree with the recommendations from the College (if these exist). **As mentioned above, in our pilot of the survey, we found that it was not feasible to ask physician offices about charges for specific services. The receptionists were generally not willing to engage in a long conversation. We agree that a broader audit study of the fees charged for specific services and alignment with College recommendations would be useful, but this was outside the scope of this study. We have added a note to this effect in the Interpretation on page 9: "*Finally, more information is needed on the uninsured services for which physicians are most commonly charging patient fees and the concordance of billing rates with regulatory guidance*."** **We also added a list of recommended fees for select uninsured services across provinces, to provide readers with a sense of the magnitude of fees.** Although the paper talks about "a wide range of medical and administrative "uninsured services" commonly provided by family physicians that are not covered by public insurance", the paper also does not go into detail about precisely what these are, how many patients would use them, and the potential consequences of not covering them. For example, the paper notes that "the most commonly reported services covered by the fee were form completion, doctor's notes, and prescription renewals (by telephone or email)". The extent to which people would need such services would presumably depend on when (and why) these are required. For example, there is some dispute about when, and whether, employers require doctor's notes for sick days; those working for employers who do not would presumably have less need for them. Similarly, there is considerable variability in how prescription renewals might be handled (sicker patients, who would also need to be seen by the doctor, presumably would also have an office visit and therefore not need to pay for the renewal). The conclusions to this paper talk about potential "adverse consequences for patients" but without discussing how, and when, this is likely to occur. **As noted in previous replies, we agree that more research into how many patients actually pay these fees and for which services is warranted. We added detail in the Interpretation on suggestions for future research and how data to facilitate this research could be collected in a systematic way.** A minor point, but in the results, they note the characteristics of their physician respondents, without comparing

	this to the distribution of the population of physicians in Ontario (they do cite two articles, but a comparison of the distributions would probably be helpful to clarify how representative their sample is). **To assess the representativeness of the sample, we now provide statistics comparing our sample characteristics to statistics on all family physicians in Ontario on page 6: *The geographic characteristics of this sample are consistent with other descriptive data on Ontario's primary care workforce: a 2013 analysis found that 9.3% of general practice and family physicians work in rural areas of the province.(22) However, our sample had a lower proportion of capitation-based payment than other reports. An analysis of Ontario physician compensation from 2015-2016 reported that 38% of family physicians were enrolled in a capitation-based payment model.(23)*** **We also note the differences in the proportion of physicians with capitation-based payment in the limitations on page 8: "*Finally, we identified a lower proportion of physicians enrolled in a capitation-based payment model compared to other reports.(25) This likely reflects the low specificity of the method used to allocate physicians to capitation-based models based on information on the Government of Ontario website (which may not be complete or updated). As a result, our comparisons of fee prevalence across payment models are likely attenuated.*"** The tables also could be clearer. For example, in Table 2, presumably the % figures are summed across each row (although there is no column with the totals), but it is less clear what the p value refers to. It is also unclear why the authors need to present tables and figures that appear to give the same data. **Yes, the totals sum across the rows. We added a note to Table A2 to clarify the statistical test, see page 13: "Statistical significance is from a survey design-based Pearson chi square test of the null hypothesis that there is no association between fee structure and geography or payment model (i.e. the categorical variables are independent)."** **We also moved Tables 1 and 2 to the appendix to avoid redundancy with the text and figures. We still include the tables in the appendix so readers have access to the exact point estimates and confidence intervals in the figure.** The discussion and conclusions refer to "the widespread use of fees for uninsured services", but their data only addresses the fact that most doctors charge such fees on occasion to some patients for some things. As such, the conclusions are not, in my view, justified by the data given. **We removed this sentence and we edited the manuscript throughout to be clear that we estimate only the prevalence of use of fees by physicians and not the prevalence of fees paid by patients. We add a note to make this clear in the limitations on page 8: "Second, we only estimate the prevalence of use of fees by physicians and not the prevalence of fees paid by patients. There is no available source of data**

	to validate whether (and how often) individual physicians actually charge fees to their patients, nor how often these fees are paid. It is possible that relatively few patients are actually charged à la carte fees, or that few patients opt-in to the annual block fee when it is offered."