

## A Statistical Anatomy of Ontario Family Physicians' Practices

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8 **Abstract** (*word count: 213, max: 250*)  
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10 **Background:** Between 2001-2006, the Ontario government introduced a menu of new primary  
11 care models (PCMs) with elements such as patient enrolment, and various combinations of fee-  
12 for-service, capitation, and pay-for-performance payments. Prior to the primary care reforms,  
13 most family physicians were paid solely through fee-for-service. All but one of the new PCMs  
14 require family physicians to practice in groups of three or more.  
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20 **Methods:** We use administrative data for April 2010 to March 2011 containing information on  
21 family physicians' demographic characteristics, frequency of visits provided to patients, and  
22 other practice information vary across PCM. The analysis sample contains 11,626 family  
23 physicians.  
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28 **Results:** Capitated models have younger FPs (50.6). Fewer female FPs are in FFS than in  
29 capitated PCMs (40%). FPs saw and/or rostered an average of 1,888 patients with notable  
30 variation between models. Average practice sizes in capitated PCMs are slightly larger than  
31 average, with non-capitated PCMs even larger.  
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36 **Interpretation:** The new models have attracted family physicians who provide traditional family  
37 medicine, with some marked differences observed across models. Among rostered patients, a  
38 high percentage see family physicians outside of the physician and the group with which they are  
39 rostered. Our results suggest group-based PCMs may not have a large impact on team integration  
40 and ensuring continuity in the provision of primary care services.  
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48 **Keywords:** Family Medicine, General Practice, Primary Care, Health Economics, Health Policy  
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## 1. Introduction

Between 2001-2006, the Ontario government introduced a menu of new primary care models (PCMs) characterized by requirements such as formal patient enrolment (i.e., rostering), team-based care, and physician remuneration for direct patient care based on various combinations of fee-for-service (FFS), capitation, pay-for-performance and salary payments. Team-based care is present in all (but one) new PCM by requiring the affiliation of three or more physicians in a group. All new PCMs require the provision of after-hours services. This is a dramatic change in Ontario's primary care landscape. For example, in 2000-01 approximately 98.4% of family physicians (FPs) were paid using FFS alone (not combined with other payment methods). However, by 2010-11 only 35.1% were paid traditional FFS with the remainder in a new PCM for at least part of the year. Barring a current entry cap of 20 physicians per month for capitation-based models, new PCMs are voluntary and Ontario FPs can join at any time. As of March 2011, close to 10 million out of 13.9 million Ontario Health Insurance Plan (OHIP) beneficiaries were rostered. Several published documents provide detailed discussions of Ontario's primary care models [e.g., 1, 2].

Although research is ongoing in primary health care and family physician payment methods, little is known about the basic characteristics of the different PCMs such as the characteristics of FPs, number of patients by enrolment status, number of visits per patient, percentage of patients who see only their rostering family physician/group, and the extent to which patients see more than one physician in their rostering group. This paper aims to fill this gap by presenting a basic statistical anatomy of primary care practices in Ontario from the perspective of the FP and highlights differences across the most common PCMs and patient status (i.e., patients seen and/or rostered).

## 2. Data and Methods

Our data are extracted from three linked administrative databases for the period April 1 2010 to March 31 2011. First, information on physicians (age, sex, country of medical graduation, PCM affiliation, rurality) come from the Corporate Provider Database (CPDB). Second, information on

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4 patient claims history comes from the OHIP database. Finally, patient roster information comes  
5 from the Client Agency Program Enrollment (CAPE) database. All individual identifiers were  
6 encrypted by the Ontario Ministry of Health and Long-Term Care to anonymize the data. The  
7 research was approved by the Hamilton Integrated Research Ethics Board (#11-086-C).  
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11 We use the term 'family physicians' to refer to both 'general practitioners' and physicians with a  
12 specialty in 'family medicine' as listed in the CPDB. We then restricted the sample to active FPs  
13 who either: (i) billed at least one dollar for either of the three most common fee codes submitted  
14 by FPs, and/or (ii) rostered at least one patient in a PCM during the year. The three most common  
15 fee codes are A007 (intermediate assessment), A001 (minor assessment), and A003 (general  
16 assessment). We then deleted an additional small number of FPs whose practice size exceeded  
17 10,000 while the percentage of total billing represented by the three most common fee codes was  
18 under 20%. Our final sample includes 11,626 family physicians and approximately 13.9 million  
19 patients.  
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23 A FP was classified as an International Medical Graduate (IMG) if they obtained their medical  
24 degree outside of Canada and the United States [12]. Practice rurality is defined using the  
25 Rurality Index of Ontario (RIO) where 0 represents major urban areas and 100 extremely remote  
26 ones [13]. The number of days worked were calculated based on the number of distinct days on  
27 which a FP provided at least one service.  
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## 30 31 32 33 34 35 36 37 38 39 40 41 **2.1. Primary Care Model Classification**

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43 We classified primary care models into four broad groups: (i) FFS, (ii) non-capitated, (iii)  
44 capitated, or (iv) other. The FFS group includes a heterogeneous mix of traditional "full-service"  
45 primary care, FPs who practice a formal specialty in addition to family medicine, part-time  
46 physicians, locums, and so-called FP-specialists whose practices focus on such areas as sports  
47 medicine and psychotherapy.  
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51 The non-capitated group includes: (a) Family Health Groups (FHGs), which are paid prevalently  
52 FFS with some incentive and bonus components and a small fee for rostering patients; (b)  
53 Comprehensive Care Management (CCM), which is similar to FHGs in its payment mechanism  
54 except it is not a group payment model; and (c) Rural models. The following PCMs were  
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classified as rural: Rural and Northern Physician Group Agreement (RNPGA), Group Health Centre (GHC), Community Sponsored Agreements, and the Weeneebayko Area Health Authority (WAHA). Rural models tend to be distinct from the other non-capitated models as their remuneration is more complex and frequently not FFS (as their rural location may limit the number of patients of the practice).

The capitated group includes: (a) Family Health Organizations (FHOs), which are paid blended capitation with FFS, together with some incentives and bonuses components; and (b) Family Health Networks (FHNs), which are similar to FHOs except with a smaller capitation component.

Although FPs can be affiliated with only one PCM at a time, some FPs changed PCMs through the year. We classified FPs affiliated with the same PCM all year in model-specific categories, including the FFS PCM for FPs not affiliated with any PCM all year. Physicians who changed between CCM and FHGs, and between FHNs and FHOs, are separately classified into unique groups. All remaining FPs are classified to the “other” PCM.

While all PCMs undoubtedly have relationships with non-rostered patients with no visits in that year, traditional FFS are more likely to have such patients. Further, since the FFS PCM does not roster patients it has no equivalent to the category “rostered only (and not seen)” observed for the other models. This affects the interpretation of the FFS practice size.

## 2.2. Definition of Patient Visit

We define a patient visit with a family physician as all claims submitted by the same FP for the same patient on the same day since FPs may submit multiple claims during a single encounter with a patient. We included all services provided by FPs except for laboratory services (defined as physician fee codes beginning with an L), walk-in services (fee code A888A), and Emergency Department services (defined as fee codes beginning with an H).

## 2.3. Defining Patients as Seen, Rostered, or Both

Patients are assigned to FPs based on their having seen or been rostered with a FP. This excludes the (approximately) 2 million OHIP beneficiaries who were neither rostered nor saw any FP during the study year. Based on this approach from the perspective of the physician, patients may

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4 be counted multiple times depending on the number of distinct FPs they were either rostered with  
5 and/or saw.  
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### 8 9 10 **3. Results**

#### 11 12 **3.1. Physician Characteristics**

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16 Table 1 presents descriptive statistics by PCM. Panel A describes the characteristics of family  
17 physicians (FPs). The three most popular PCMs are: FFS (35.1%), FHGs (23.8%), and FHOs  
18 (23.7%). The average number of other FPs a FP interacts with by PCM is higher for most non-  
19 capitated PCMs (59.7 for FHGs) than for capitated PCMs (16.1 for FHOs and 10.4 for FHNs).  
20 This suggests FHGs tend to be very large groups relative to other PCMs.  
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26 Ontario FPs are (on average) 51.3 years of age, 38% female and 24% are IMGs. Capitated  
27 models have younger FPs (50.6) while non-capitated models have older FPs (52.7). There are  
28 fewer female FPs in FFS (36%) and more in capitated PCMs (40%). A lower share (15%) of FPs  
29 in capitated PCMs are IMGs relative to non-capitated PCMs (33%). The average FP in Ontario  
30 billed 206 days per year. FPs in capitated (236 days) and non-capitated (237 days) PCMs billed  
31 more days per year. FFS FPs billed fewer days (160 days).  
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38 **<Insert Table 1 here>**

#### 39 40 41 **3.2. Practice Size and Average Visits Per Patient**

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43 Panel B of Table 1 shows the mean number of patients seen or rostered. The total provides a  
44 sense of practice size. The average practice size is 1,888 patients. Average practice sizes are  
45 slightly larger among capitated PCMs (2,046 patients) and much larger among non-capitated  
46 PCMs (2,528 patients).  
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51 Next we decompose the total practice size into three patient sub-components: (i) seen (not  
52 rostered), (ii) rostered (but not seen), and (iii) rostered and seen. What is immediately evident is  
53 (as noted above) the practice size for FFS physicians is simply the patients seen, since FFS  
54 practices do not roster patients. The majority of patients were rostered in both non-capitated  
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(53.4%) and capitated (71.1%) PCMs. A small share of patients were rostered but not seen in both capitated (21.6%) and non-capitated (14.8%) PCMs.

Figure 1 deconstructs the average total practice size, showing the percentage of FPs by practice size (defined in increments of 500 patients). The four PCMs have somewhat of a Bell curve distribution with FPs having most commonly a practice size between 1,500 and 2,500 patients. There is a notable percentage (4.7%) of FPs with practice sizes exceeding 5,000, with a majority of these FPs (91%) being in FHGs.

**<Insert Figure 1 here>**

Panel C of Table 1 presents the average number of visits per patient. On average patients saw a FP 2.8 times a year, and across all PCMs rostered patients saw their FPs more (2.9 to 3.0 visits) than did non-rostered patients (2.6 visits). With the exception of rural models, FPs in non-capitated models on average saw their patients more frequently in the year than did those in capitated practices.

Figure 2 deconstructs the average number of visits per patient, and shows the percentage of FPs by the average number of visits per patient. Whereas between 71% and 87% of FPs in PCMs see their patients between 2 and 5.9 times, only 33% of FFS FPs are in this group. The FFS group is somewhat of a polarized group by having a very high concentration (56% of FFS FPs) in the “1 to 1.9” visits category and, at the opposite end of the spectrum, presenting a relatively large percentage seeing their patients an average 6 or more times. Of all FPs seeing their patients 6 or more times on average, 82% are in the traditional FFS payment model.

**<Insert Figure 2 here>**

Given the economic incentives, it is unexpected for FFS FPs to have smaller practices than FPs in PCMs. It is also unexpected in Figure 4 for FFS FPs to have a large mode at one visit per patient, while the alternative PCMs have modes above one visit. However, we calculated average dollars per visit and per patient and found a substantial amount of up-serving and up-coding by FFS family physicians compared to PCMs, particularly amongst those FFS family physicians seeing their patients most often.



One of the key goals of both rostering and capitation is to encourage a relationship between the patient and their rostering FP (and the physician's group who share medical records), in hopes of improving continuity of care (sometimes called a patient's medical home). Table 2 compares the average percentage of patients in an FP's practice who saw only one FP during the year. Compared to results from a decade earlier when 25.8% of patients in an FP's practice saw only one FP, reforms in primary care appear to have had a very modest increase with respect to continuity of care.

<Insert Table 2 here >

FPs in FFS present the weakest family doctor-patient relationship in terms of visit frequency as a very low 14.2% of patients saw only one FP. Despite enrolment being a cornerstone of PCMs with the implicit objective of enabling continuity of primary care services so to more effectively deliver comprehensive primary care [3], the four most common PCMs perform only slightly better with 17.7% (FHGs) to 28.8% (CCMs) of patients (See Table A1) having an exclusive relationship with their rostering physician.

### 3.3. Distribution of Patients in a Practice by Enrolment Category and Visit Group

Although this study is from the perspective of the physician, we classified patients (from their perspective) into 5 mutually exclusive enrolment status categories — Enrolment Categories A through E — and for each enrolment category we allocate patients to 6 mutually exclusive patient visit status groupings — Visit Groups 1 to 6. The 6 visit groups classify patients based on their (i) formal enrolment status, and ii) observed patterns of visits with all FPs in the study year. This patient classification is then tabulated from the FP's perspective to reveal the nature of the patient population seen, on average, by those physicians in each practice model. The full table detailing the average percentage of patients by Enrolment Category A to E and Visit Group 1 to 6 for FFS and the five most common PCMs moving towards increasingly “reformed” models on the right can be found in appendix Table A1.

Figure 3 illustrates the percentage of patients in a practice (i.e., the same percentages in Table A1) by the five rostering categories —i.e. Enrolment Categories A to E— for CCMs, FHGs, FHNs and FHOs. Figure 3 illustrates, regardless of PCM, the high percentage of Enrolment



Category E patients. Across the 4 PCMs, the largest category of patients in the practice is patients rostered all year with this FP.

**<Insert Figure 3 here>**

Figure 4 illustrates the percentage of patients in a practice by our six major Visit Groups. We interpret Figure 4 to paint a “glass half empty/glass half full” picture as PCMs show relatively greater stability with 26% to 38% of patients being Visit Group 1 patients as opposed to 14% for FFS. This highlights a good result especially comparing Visit Group 1 in FFS against CCM, as both PCMs are similar. However, PCMs also display a mediocre outcome with a low percentage of Visit Group 2 patients pointing to little within-group coverage and a particularly high percentage of Visit Group 3 patients; this is remarkable considering that walk-in and emergency services have been excluded.

**<Insert Figure 4 here>**

### **3.4. Other Characteristics**

Table 3 presents the percentage breakdown of total patient visits broken down into three service categories: (1) primary care services defined as all services included in the FHO basket of capitated services; (2) walk-in, and emergency or emergency-equivalent services; and (3) all other non-laboratory services provided by FPs. To test the reliability of our results, we conducted an alternative analysis employing slightly different definitions of primary care visits and obtained very similar results (not shown).

CCMs and/or FHGs provided on average the highest percentage of primary care services while FFS and FHNs provided the lowest. As hinted to earlier, this percentage of primary care services goes hand-in-hand with practice size as the PCMs with the lowest (highest) percentage of primary care visits (i.e., FFS, FHNs and rural models (FHGs and/or CCMs) also have the smallest (largest) practices).

**<Insert Table 3 here>**

## Interpretation

Primary Care Reform in Ontario appears to have successfully shifted family physicians (FPs) away from FFS towards the newer PCMs. It appears FPs who provide more traditional family medicine and who have a relationship with their patients (with respect to visit frequency and visit group) have transitioned to the newer PCMs. FPs who are relatively less active, have multiple specialties, are locums, or have more unusual relationships with patients in regards to visit frequency have remained in the FFS model. The FFS model is somewhat of a polarizing group with many FPs at one end of the spectrum working sporadically during the year, having small practices and seeing patients only once but others at the other end seeing their patients more than 6 times a year. The FHG and CCM blended FFS models attract physicians with the largest practices.

FPs in most PCMs have rostered 50% to 70% of patients in their broadly-defined practice. However, we also find practices are made up of a surprisingly high percentage of patients who see FPs but are not rostered neither with them nor with other physicians in the group. From the perspective of team integration and ensuring continuity in the provision of primary care services, group-based models do not appear to be making a large impact. The FHG model appears to perform relatively the worst having the lowest percentage of Enrolment Category A and Visit Group 1 patients and the highest percentage of Enrolment Category E and Visit Group 3 patients. Relatively lower group coverage in FHGs compared to FHNs and FHOs may be explained in part by the lack of financial penalties that the latter are subject to when rostered patients seek care outside of the group. Despite continuity being associated with high quality care [4-8], recent literature has begun to emphasize how continuity is increasingly threatened by access to specialized or readily available care [4, 9, 10].

What seems clear is not all practices are the same. Younger FPs and female FPs are more likely to practice in a capitated PCM (FHO and FHN). Non-capitated PCMs (FHGs specifically) have larger practice sizes. What is not immediately clear, is how FP practice style varies with the size and composition of their practice. As others have highlighted [11], we conclude the benefits of Ontario's PCMs are still to be fully achieved. These results have important implications for future primary care policymaking.

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**Table 1: Characteristics of Family Physicians by Primary Care Model, 2010-11**

Panel	A							B				C				
	Primary Care Model Categories	No. (col. %)	Mean Age	% Female	% IMG	Average no. of group FPs they interacted with	Days billed	Mean RIO	Mean Patients Seen or Rostered (row %)				Average Number of Visits per Patient, by Patient Category			
									Rostered Only	Seen Only	R. and Seen	All	Rost. All Year	Rost. < Year	Not Rost. w/MD	All
Traditional fee-for-service (FFS)	4,087 (35.1%)	51.5	36%	23%	0	160	8.2	-*	1,332	-*	-*	-	-	3.2	3.2	
<b>Non-capitated Enrolment Models</b>																
Family Health Groups (FHG)	2,768 (23.8%)	52.6	39%	33%	59.7	237	4.0	372 (14.1%)	1,277 (48.3%)	994 (37.6%)	2,643 (100%)	3.4	3.1	2.5	3.0	
Comprehensive Care Management (CCM)	279 (2.4%)	56.0	30%	41%	0	241	11.2	364 (17.0%)	704 (32.9%)	1,073 (50.1%)	2,142 (100%)	3.9	3.2	3.0	3.6	
Rural models	179 (1.5%)	49.9	33%	12%	8.8	235	63.3	376 (25.6%)	450 (30.6%)	644 (43.8%)	1,470 (100%)	2.5	2.4	2.4	2.4	
CCM and FHG	99 (1.0%)	50.1	42%	38%	32.2	235	3.5	436 (18.6%)	1,117 (47.7%)	788 (33.7%)	2,342 (100%)	3.4	3.2	2.1	2.7	
Sub-Total (Non-Capitated)	3,325 (28.6%)	52.7	38%	33%	51.2	237	7.8	373 (14.8%)	1,179 (46.6%)	976 (38.6%)	2,528 (100%)	3.4	3.0	2.5	3.0	
<b>Capitated Enrolment Models</b>																
Family Health Organizations (FHOs)	2,757 (23.7%)	50.9	40%	15%	16.1	234	16.0	441 (21.2%)	595 (28.5%)	1,048 (50.3%)	2,085 (100%)	2.6	2.8	2.1	2.4	
Family Health Networks (FHNs)	312 (2.7%)	49.2	37%	12%	10.4	256	49.1	364 (20.4%)	627 (35.1%)	794 (44.5%)	1,785 (100%)	2.8	3.3	2.0	2.5	
FHN and FHO	124 (1.1%)	49.3	48%	11%	7.8	238	14.8	673 (36.2%)	402 (21.6%)	785 (42.2%)	1,860 (100%)	2.4	2.7	2.1	2.2	
Sub-Total (Capitated)	3,193 (27.5%)	50.6	40%	15%	15.1	236	19.2	443 (21.6%)	591 (28.9%)	1,013 (49.5%)	2,046 (100%)	2.6	2.8	2.1	2.4	
Other	1,021 (8.8%)	47.7	48%	30%	25.1	191	13.1	297 (19.4%)	723 (47.2%)	512 (33.4%)	1,532 (100%)	2.8	2.6	1.9	2.2	
<b>Total</b>	<b>11,626 (100%)</b>	<b>51.3</b>	<b>38%</b>	<b>24%</b>	<b>32.4</b>	<b>206</b>	<b>11.5</b>	<b>254 (13.5%)</b>	<b>1,031 (54.6%)</b>	<b>602 (31.9%)</b>	<b>1,888 (100%)</b>	<b>3.0</b>	<b>2.9</b>	<b>2.6</b>	<b>2.8</b>	

\* For FFS physicians the counts for "Rostered", "Rostered and Seen", and "All" are not comparable to the other PCMs. As such, we have not included them in the table.

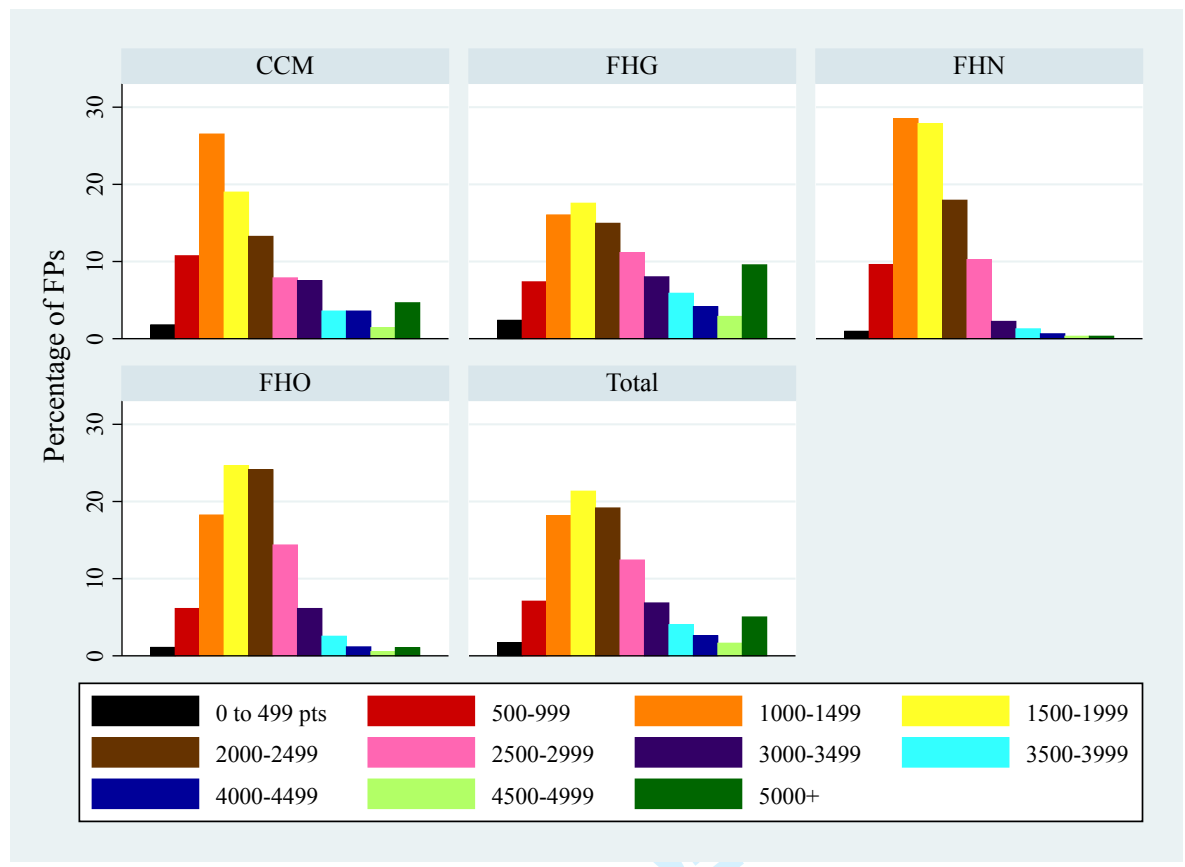
**Table 2: Average Percentage of Patients in an FP's Practice Who Saw One FP in the Year, by Patient Category and Group, Selected Primary Care Models**

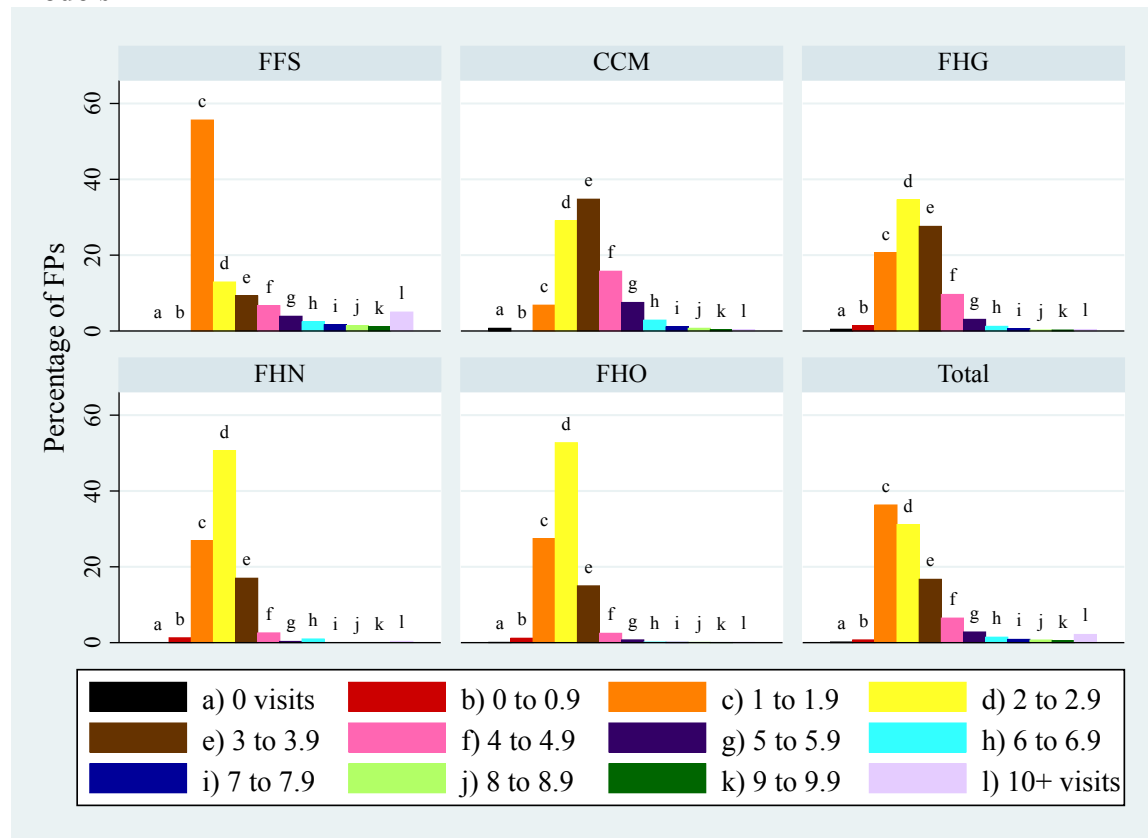
	All FPs	FFS	CCM	FHG	FHN	FHO
<b>2000-01</b>	25.8% (4,100,387 patients overall)	25.4%	Not applicable (model did not exist)	Not applicable (model did not exist)	Not applicable (model did not exist)	56.8
<b>2010-11</b>	28.7% (5,264,305 patients overall)	14.2%	47.7%	32.9%	39.5%	41.8%

**Table 3: Percentage Breakdown of Total Visits by Service Type**

Primary Care Model	Primary care services*	Walk-in or emergency services	Other Services
<b>Not Capitated</b>			
Traditional fee-for-service (FFS)	54.8%	14.6%	30.6%
Family Health Groups (FHG)	75.1%	3.0%	21.9%
Comprehensive Care Management (CCM)	76.4%	2.0%	21.5%
Rural models	63.3%	5.0%	31.7%
CCM and FHG	77.0%	2.6%	20.4%
Sub-Total (Non-Capitated)	63.7%	9.5%	26.9%
<b>Capitated</b>			
Family Health Organizations (FHOs)	67.8%	3.4%	28.8%
Family Health Networks (FHNs)	56.7%	9.6%	33.7%
FHN and FHO	64.5%	4.8%	30.7%
Sub-Total (Capitated)	66.6%	4.1%	29.3%
<b>Other</b>	68.8%	5.1%	26.1%
<b>Total</b>	64.9%	7.6%	27.5%

Figure 1: Percentage of FPs by Practice Size, Selected Primary Care Models

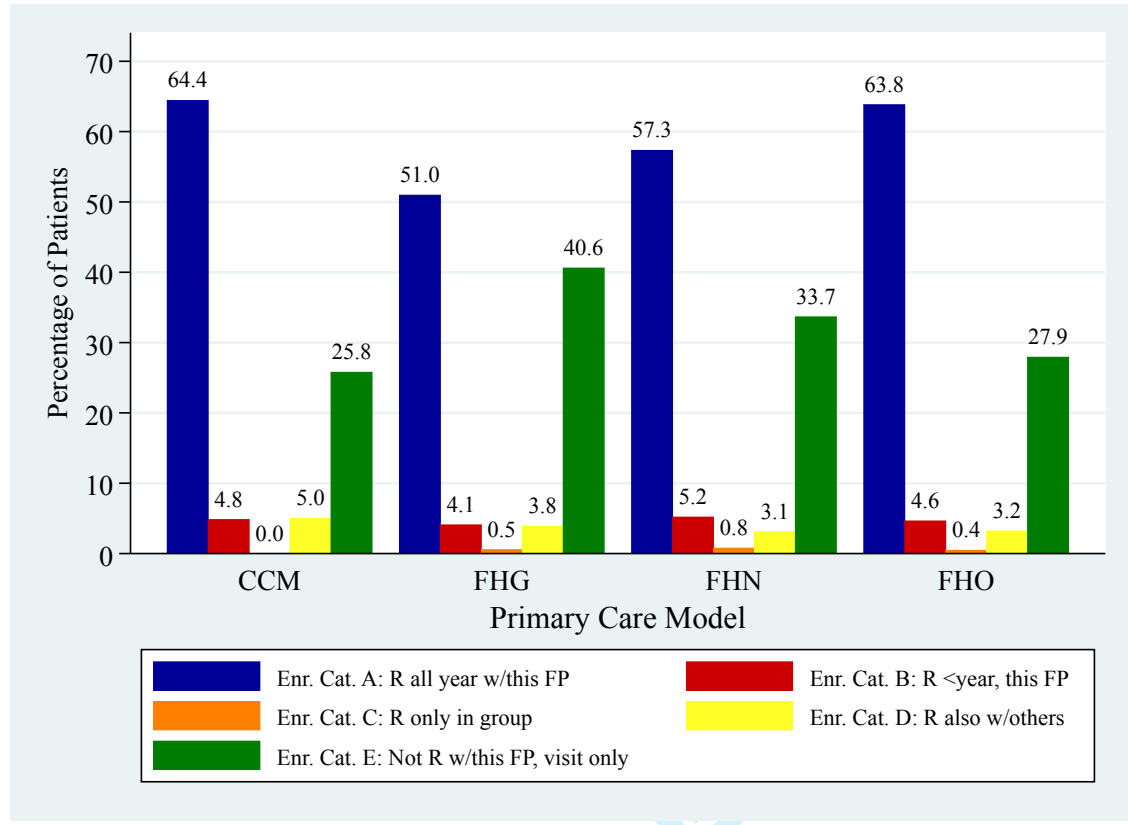


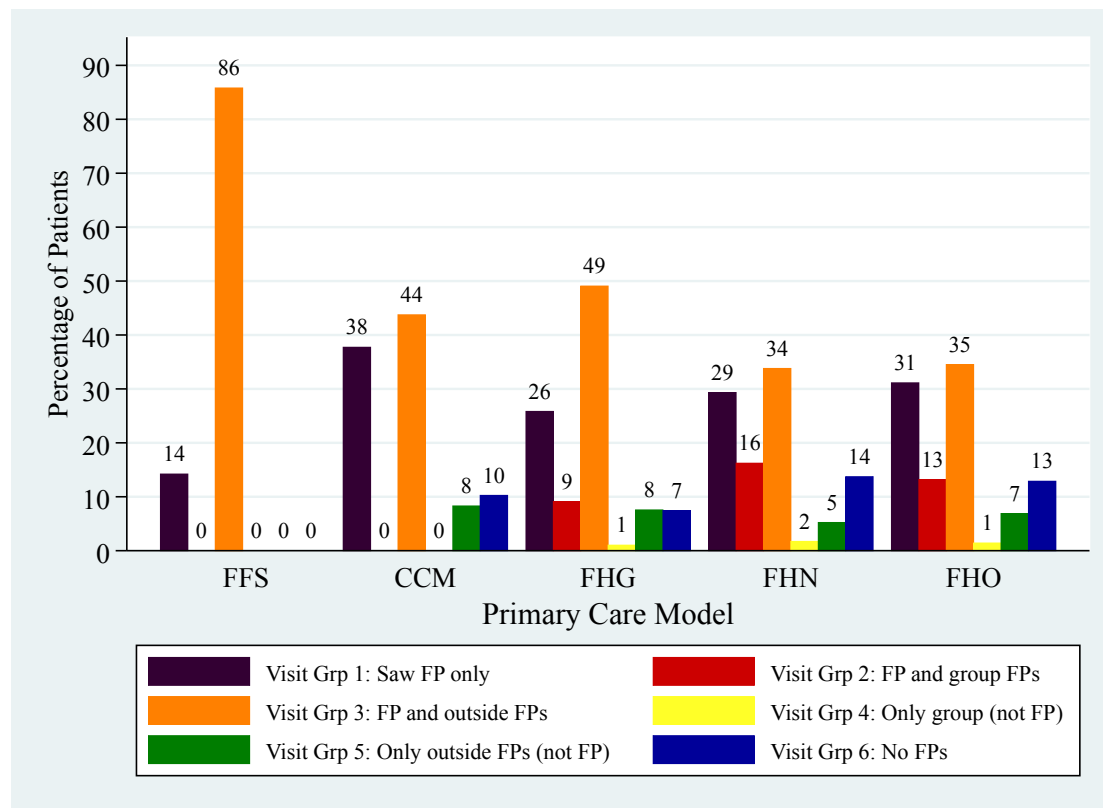
**Figure 2: Percentage of FPs by Mean Number of Visits\* per Patient, Selected Primary Care Models**

\* Visits related to primary care or other services only. I.e. walk-in and emergency services are excluded.



Figure 3: Percentage of Patients by Patient Enrolment Category, Selected Primary Care Reform Models



**Figure 4: Percentage of Patients by Visit Group, Selected Primary Care Models**

## Appendix

**Table A1: Average Percentage of Patients by Patient Category and Group, Selected Primary Care Models**

	FFS	CCM	FHG	FHN	FHO
Enrolment Category A: Patients rostered all year with FP and saw....					
Visit Group 1) FP only	-	28.8%	17.7%	22.3%	24.8%
Visit Group 2) FP and group	-	-	2.9%	5.5%	4.7%
Visit Group 3) FP and outside FPs	-	19.7%	16.4%	11.3%	15.6%
Visit Group 4) Only group (not FP)	-	-	0.9%	1.4%	1.2%
Visit Group 5) Outside FPs (not FP)	-	6.1%	5.8%	3.8%	5.2%
Visit Group 6) No one	-	9.8%	7.2%	13.0%	12.3%
Enrolment Category B) Patients rostered part year with FP, did not roster with anyone else and saw....					
Visit Group 1) FP only	-	2.1%	1.5%	1.9%	1.6%
Visit Group 2) FP and group	-	-	0.3%	0.5%	0.3%
Visit Group 3) FP and outside FPs	-	2.0%	1.8%	1.7%	1.8%
Visit Group 4) Only group (not FP)	-	-	0.0%	0.1%	0.1%
Visit Group 5) Outside FPs (not FP)	-	0.4%	0.3%	0.4%	0.5%
Visit Group 6) No one	-	0.3%	0.2%	0.5%	0.4%
Enrolment Category C) Patients rostered part year with FP, rostered with other group FPs and saw....					
Visit Group 1) FP only	-	-	0.1%	0.1%	0.1%
Visit Group 2) FP and group	-	-	0.1%	0.1%	0.1%
Visit Group 3) FP and outside FPs	-	-	0.2%	0.2%	0.1%
Visit Group 4) Only group (not FP)	-	-	0.1%	0.2%	0.1%
Visit Group 5) Outside FPs (not FP)	-	-	0.1%	0.1%	0.1%
Visit Group 6) No one	-	-	0.0%	0.1%	0.0%
Enrolment Category D) Patients rostered part year with FP, rostered with other FPs and saw....					
Visit Group 1) FP only	-	0.6%	0.4%	0.5%	0.4%
Visit Group 2) FP and group	-	-	0.1%	0.2%	0.1%
Visit Group 3) FP and outside FPs	-	2.5%	1.9%	1.4%	1.4%
Visit Group 4) Only group (not FP)	-	-	0.0%	0.1%	0.1%
Visit Group 5) Outside FPs (not FP)	-	1.8%	1.4%	0.9%	1.1%
Visit Group 6) No one	-	0.1%	0.0%	0.1%	0.1%
Enrolment Category E) Patients not rostered with FP and saw....					
Visit Group 1) FP only	14.2%	6.3%	6.2%	4.6%	4.3%
Visit Group 2) FP and group	-	-	5.7%	9.9%	7.9%
Visit Group 3) FP and outside FPs	85.8%	19.5%	28.8%	19.2%	15.7%
Total	100%	100%	100%	100%	100%