

The Consequences of Delisting Publicly Funded, Community-Based Physical Therapy Services in Ontario: A Health Policy Analysis

Melanie Gordon, Barbara Waines, Jennifer Englehart, Susan Montgomery, Rachel Devitt, Paul Holyoke, Cheryl A. Cott, and Michel D. Landry

ABSTRACT

Purpose: Because publicly-funded, community-based physical therapy (PT) services through Ontario's network of Schedule 5 providers were partially delisted in April 2005, we examined the perceived consequences of this policy decision among different provider categories following partial delisting. Schedule 5 providers or clinics, renamed "Designated Physiotherapy Clinics" following partial delisting, are privately-owned and operated facilities that have agreements with Ontario's Ministry of Health and Long-Term Care to deliver publicly funded services for eligible clients.

Methods: A health policy research approach used semi-structured telephone interviews with 33 physical therapists from Schedule 5 clinics, home care settings, hospitals, and private clinics within the Greater Toronto Area and across Ontario.

Results: Schedule 5 providers perceived an immediate decrease in demand, whereas PT providers from other categories reported no change at the time of interview. Conversely, all providers forecasted decreased access for ineligible clients but a potential for improved access and reduced wait times among those who remained eligible. In the final analysis, PT informants in all categories agreed that partial delisting was an improved policy decision compared with full delisting, as proposed initially.

Conclusions: Perceived consequences appeared to depend on provider type. However, informants from all provider categories cautioned that this policy decision would have a significant impact on the health status of some Ontarians. Further research is warranted to explore the long-term effects of this policy decision.

Key words: delisting, elasticity, funding, health policy, physical therapy

RÉSUMÉ

Objectif: Étant donné qu'ils sont financés publiquement, les services de physiothérapie communautaires fournis par le biais du réseau ontarien des fournisseurs visés à l'article 5 du Règlement ont été partiellement radiés en avril 2005, et nous avons examiné les conséquences de cette décision stratégique parmi les différentes catégories de fournisseurs après la radiation partielle. Les fournisseurs ou les cliniques visés à l'article 5 du Règlement, renommés «Cliniques de physiothérapie désignées» après leur radiation

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partielle, sont des établissements détenus et gérés par des intérêts privés qui ont des accords avec le Ministère de la Santé et des Soins de longue durée de l'Ontario en vue de fournir des services financés de source publique aux clients admissibles.

Méthodologie: Une approche adoptée pour la recherche en politique sur la santé a utilisé des entrevues téléphoniques semi-structurées auprès de 33 physiothérapeutes provenant de cliniques visées à l'article 5 du Règlement, de contextes de soins à domicile, d'hôpitaux et de cliniques privées de la région du Grand Toronto et d'Ontario.

Résultats: Les fournisseurs visés à l'article 5 du Règlement ont perçu une réduction immédiate de la demande, alors que les fournisseurs de services de physiothérapie d'autres catégories n'ont rapporté aucun changement au moment de l'entrevue. Inversement, tous les fournisseurs ont prévu une réduction de l'accès aux soins pour les clients non admissibles, mais la possibilité d'une amélioration de l'accès aux soins et un temps d'attente réduit parmi ceux qui demeuraient admissibles. Lors de l'analyse finale, les physiothérapeutes interrogés dans toutes les catégories ont convenu que la radiation partielle était une décision stratégique supérieure à la radiation totale, comme on l'avait proposée initialement.

Conclusions: Les conséquences perçues dépendaient du type de fournisseurs de services. Cependant, les personnes interviewées provenant de toutes les catégories de fournisseurs ont mis en garde que cette décision stratégique aurait un impact important sur l'état de santé de certains Ontariens. D'autres recherches sont nécessaires pour explorer les effets à long terme de cette décision stratégique.

Mots clés: élasticité de la demande, financement, physiothérapie, politique en matière de santé, radiation

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The financial sustainability of the publicly funded health-care system has generated debate across Canada. The Canadian Institute for Health Information reported that health spending reached \$142.0 billion in 2005, representing a 7.7% increase from 2004.¹ Owing to these fiscal pressures, the public policy agenda now includes discussions of ways to slow the rate of health-care expenditures, often by shifting health services' funding responsibility from public (e.g., government) to private (e.g., insurance, workers' compensation) sectors.²⁻⁴

The Canada Health Act stipulates that for a province to receive federal transfers for health spending, residents shall receive, at no direct cost, all medically necessary services provided by physicians and/or in-hospital (core services) and any other services (non-core services) that a province may decide to provide. Accordingly, provincial governments are not required to insure health services provided outside hospitals and have the flexibility to make funding changes to community-based services.^{2,3,5-8} Using this as a policy lever, the government of Ontario de-insured or delisted hearing tests for residents in 2001.⁹ At the time of delisting hearing tests, the government reported that physical therapy (PT) services funded through community clinics, known as Schedule 5 providers, would be delisted also. At the last minute, the decision was reversed and Schedule 5 funding remained intact.¹⁰ The 2004 Ontario Budget, however, announced that public funding for Schedule 5 clinics would be delisted as of April 2005.¹¹ Such a reduction in public funds for PT could have consequences, including potential loss of PT access for low-income individuals, increased wait times for

other health-care providers and negative health sequelae, potentially leading to increased incidence of chronic conditions.^{2,3,5}

This delisting event represented a naturally-occurring health policy experiment that allowed exploration of the consequences of delisting PT services on consumers and providers. Shi stated that the "complexity of problems addressed in health services and their variation in time and place complicate analytic research efforts in health services research."¹² Health policy research, a subset of health services research, examines the health-care system and health policy-making processes, often through triangulation of available data sources, to build a comprehensive understanding of the underlying policy and its implications. The outcomes of policy research provide in-depth understanding of the effects of policy implementation (or lack of implementation) on different stakeholder groups, such as clients, providers and the overall health system.^{13,14} A health policy research approach was adopted to enable the investigators to explore the immediate and short-term consequences of delisting PT services in Ontario.

The study's purpose was to examine the consequences of delisting PT services from the perspective of community-based PT service providers. The history of Schedule 5 clinics in Ontario is described, followed by a review of the consequences of delisting health services. The results of key informant interviews with community-based PT service providers after delisting are reported, and, finally, a discussion about the policy implications of these findings for clients, providers and the health system is presented.

THE CONTEXT: THE HISTORY OF SCHEDULE 5 CLINICS IN ONTARIO

In 1964, Ontario's Ministry of Health acknowledged that hospitals would benefit from publicly funding, community-based PT services to address pressures in decreasing inpatient length of stay. At the time, the Ontario Ministry of Health provided physical therapists with an opportunity to invoice the provincial health-care system or the Ontario Hospital Insurance Plan (OHIP) for their services if they opened a private practice in the community. As a result, 120 agreements (originally termed Schedule 9 and then renamed Schedule 5) were issued to physical therapists.¹⁰ These agreements were issued predominantly in southern Ontario; no new agreements have been made since that time.^{2,10} Although there has been a proliferation of new private practices in Ontario since the 1960s, only some can invoice OHIP for services.

Prior to April 2005, there were more than 90 active Schedule 5 providers in Ontario.¹⁵ The balance of Schedule 5 agreements has become inactive since then for unknown reasons. Following small increments made over time, the billing rate within Schedule 5 clinic-based settings was \$12.20 per client visit, with a maximum of 150 client visits per year.¹⁰ The Ontario Physiotherapy Association expressed concern regarding the low per-client payment structure, stating that this fee did not reflect the actual costs required to provide PT services.^{16,17} Others have suggested that because Schedule 5 funding represented approximately 0.2% of the total yearly expenditures by the Ontario Ministry of Health and Long-Term Care

(MOHLTC),⁵ this payment schedule, in fact, promoted efficient and cost-effective services.⁵

In the 2004 Ontario budget, it was reported that public funding for Schedule 5 providers would be fully delisted as of April 1, 2005.¹¹ However, the week before the proposed delisting, the MOHLTC amended the original 2004 budget, recommending partial versus full delisting. Public funding for PT services through Schedule 5 providers has been under examination by the Ontario government since 2001 (Figure 1).^{2,3} The 2004 provincial budget stated that to improve cancer care and cardiac programs as well as homecare and long-term care, "less critical services," such as PT, would be delisted.¹¹

Within this partial delisting policy, the MOHLTC opted to restrict eligibility criteria for publicly funded, community-based PT services rather than fully delist them.¹⁵ Previously, all publicly insured Ontario residents were eligible for PT treatment in Schedule 5 clinics. To be eligible for services from April 1, 2005, in the newly termed "Designated Physiotherapy Clinics," a resident must meet one of the following criteria: (1) aged 65 years and over, (2) aged 19 years or under, (3) reside in a long-term care facility, (4) require PT at home post-hospitalization or (5) receive social benefits. Following the partial delisting of Schedule 5 providers, Ontario remains one of only four provinces that currently offer publicly funded PT options in the community.¹⁸ Services funded within Saskatchewan, Alberta and British Columbia are also limited to a narrow portion of the population and have strict and predetermined eligibility criteria.¹⁹⁻²¹ For this article, the term "Schedule 5 provider" is used.

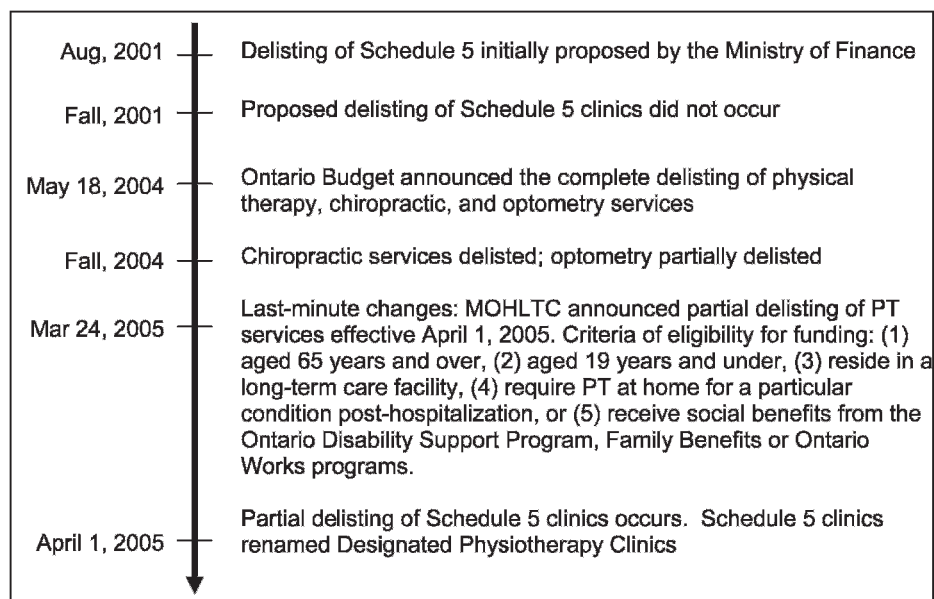


Figure 1. Timeline of proposed delisting of physical therapy (PT) services in Ontario (2001–2005). MOHLTC = Ontario Ministry of Health and Long-Term Care.

The logic of delisting a publicly funded service, such as Schedule 5 clinics, is that clients will (1) access other publicly funded services, such as homecare or hospital outpatient departments; (2) use private insurance to pay for PT services; (3) decide to pay out of pocket or (4) reduce use of PT services. The MOHLTC's assumption may have been that if services were delisted in one publicly funded sector, clients would access them elsewhere in the system. From a policy perspective, a successful transition after delisting would occur if clients could access previous services through other funding sources or other provider types. Two questions remain: (1) To what extent will consumers turn to other payment sources? and (2) What impact will consumers moving to other payment or funding sources or other publicly funded services have?

LITERATURE REVIEW

Relatively few reports in the literature have examined the effects of delisting publicly funded, community-based health-care services in Canada or elsewhere. However, the European literature has shown that client co-payments (a form of partial delisting) for drugs resulted in significant reductions in the use of essential drugs for hypertension, diabetes mellitus and thyroid conditions.²² Ess and colleagues reported that the number of prescriptions filled owing to delisting was directly related to increases in health-care costs for psychiatric services, nursing homes for the elderly and other sectors, such as hospitals and physician specialists.²² Furthermore, the effect just prior to delisting pharmaceuticals was an increase in hospital referrals by physicians to ensure access to pharmaceuticals at no direct cost to the client.²² Similarly, drug delisting for chronic venous insufficiency (CVI) resulted in decreased consultation costs from general practitioners and an overall reduction in drug prescription costs;²³ however, increased inpatient hospital costs were also reported.²³ Although delisting CVI drugs decreased short-term costs, the long-term, system-wide effect was a significant increase in hospitalization for CVI patients.²³

In a similar Canadian study, delisting corticosteroids from a publicly funded Pharmacare program decreased the number prescribed.²⁴ However, the authors argued that although annual, per-client costs decreased after delisting, the number of prescriptions of a comparable, publicly funded topical corticosteroid increased during the following year.²⁴ In another Canadian study, physicians' perspectives were sought with regard to delisting certain medications in Ontario. They reported that they would substitute publicly funded medications for delisted med-

ications when possible, especially for clients who were perceived as unable to pay privately.²⁵

In the only study on delisting of PT services, delisting across all jurisdictions in Canada decreased overall use of PT services but increased the probability of seeking PT services by those with extended health insurance.²⁶ Similarly, when PT services were delisted in British Columbia, the Canadian Physiotherapy Association reported that "delisting resulted in increased waiting times, a 28% decrease in patients accessing community-based care and reports of patients ending treatment prematurely."²⁷

METHODOLOGY

This study is part of a larger health policy research project that examined the consequences of partial delisting of PT services in Ontario for clients and providers. In keeping with health policy research, this study used a multimethod approach that included interviews with PT providers in a variety of settings two weeks prior to and two weeks after partial delisting. This research project was based on the expectation that full delisting would occur on April 1, 2005, and, as such, conducting interviews two weeks before and two weeks after delisting would have provided a sufficient time period to investigate the delisting policy. With the unanticipated implementation of partial delisting, however, the time frame between data collection phases was no longer optimal. At the time of partial delisting, informants had already agreed to specific times to conduct the after interview, and the study had received ethics approval to conduct the after interview approximately two weeks after delisting. Therefore, it was not feasible to change the study plan when the policy was changed from full to partial delisting.

Key informant interviews were conducted with physical therapists of publicly funded (i.e., hospital departments, homecare providers funded through Community Care Access Centres [CCACs]), and privately-funded (i.e., private clinics) providers most likely to be affected by delisting.

The results of the consumer component of the research are reported elsewhere.²⁸ Briefly, the authors followed clients before and after delisting to assess change in access and self-reported health status. The results indicated that 81 of 113 (71.7%) participants who required PT services continued to receive them after delisting because they remained eligible, were privately insured and/or were able to pay out-of-pocket. Twenty (17.7%) required services but did not receive them because they were uninsured or were not able or willing to pay privately. The remaining participants were discharged at follow-up. Controlling for

gender, age, employment and condition, clients who maintained access after delisting were 10 times more likely to report very good or excellent health than those who did not (odds ratio 10.72; 95% confidence interval 2.20–52.25).²⁸

The purpose of the present study was to examine perspectives of different providers of PT services on the impact of the policy decision to partially delist publicly-funded, community-based PT services. This component used telephone interviews with PT community-service providers (key informants) in two subgroups: providers in the Greater Toronto Area (GTA) and providers within five other cities across Ontario. The study received ethics approval from the University Health Network and University of Toronto Research Ethics Boards.

Selection of Key Informants

Potential key informants from the GTA group were purposively sampled from a list of participants from a previous health policy study conducted by one of the authors (M.D.L.). To be included in this study, participants were required to practise in only one provider category. The sampling frame consisted of representatives from four PT provider categories: hospital outpatient departments, homecare provider under contract with CCACs, private practices and Schedule 5 providers. Providers from the GTA were included to allow for comparisons between them and other providers across the province.

Potential key informants within the Ontario group were identified through a two-phased process. As with the GTA sample, participants were required to practise in only one of the provider categories. In the first phase, a sample of Schedule 5 clinics located in areas ranging from large urban centres to small rural towns was chosen from a list generated through the association that represents the majority of Schedule 5 clinics in the province. Then one

clinic from within each of the five Ontario Hospital Association (OHA) regions was purposively selected to determine their interest in participating in the study. OHA regions are both rural and urban. Owing to confidentiality, we are unable to disclose which cities were included.

In all cases, informed consent was obtained to participate in the interview process. Once the Schedule 5 providers agreed to participate, they were asked to provide a list of providers in the other three categories. In the second phase, a sample of providers in each of these categories was contacted and all agreed to participate in the study.

Data Collection

Key informant telephone interviews were conducted using semi-structured questions to explore providers' perspectives broadly and uncover hidden and emerging themes while maintaining the study focus.²⁹⁻³¹ This methodology has been shown to contribute significantly to health-care knowledge, thereby developing exploratory hypotheses for future studies.³¹ The after telephone interviews with the providers took place from April 18 to 25, 2005. Two student authors conducted the interviews in the GTA, and three senior authors conducted the interviews across Ontario, using a semi-structured interview guide that included six open-ended questions and structured probes (Table 1).

Each interview lasted approximately 20 minutes, was recorded on audiotape and was then immediately sent to an individual, external to the research team, for transcription. For logistical and resource reasons, interviews from the Ontario subgroup were not taped and transcribed. Instead, detailed notes were taken throughout these interviews.

Data Analysis

The research team discussed the data and performed content analysis to identify emerging themes. Content

Table 1. Semi-structured Interview Guide

1. As you may know, the delisting of Schedule 5/OHIP clinics is occurring on March 31, 2005. How do you anticipate your practice will be affected with the delisting of Schedule 5/OHIP?
2. Have you or your facility taken any measures to prepare for the change?
3. In your opinion, what will be the impact of delisting on clients? Which group of clients will be mostly affected? (*Prompt: For example, will clients and third-party insurers be required to assume a larger proportion of funding for PT services?*)
4. In your opinion, will there be a resulting impact on (1) inpatient length of stay in hospitals, (2) outpatient hospital PT programs, (3) long-term care facilities, (4) physical therapists under contract with CCAC, (5) private practice and (6) population health?
5. From your perspective, how will funds previously allocated be redistributed?
6. Do you have any other comments/opinions regarding the delisting of Schedule 5/OHIP clinics?

analysis, or qualitative description, has been reported to be beneficial when the description of phenomena is desired.³² The themes were based on collective perceptions and the experiences of the informants that addressed the research objectives.³² The transcribed data were entered into a qualitative data analysis software package (NVivo, QSR International, Doncaster, Victoria, Australia) for systematic coding. Coding was simultaneously performed by two student researchers who had not conducted the interviews. Following the interview coding, coding reports were generated so that the research team could analyze the information. The data themes from the GTA subgroup were constantly compared with the detailed field notes from the Ontario subgroup.

RESULTS

Thirty-three key informants provided informed consent to participate in the study, including 15 physical therapists within the GTA and 18 physical therapists from elsewhere in Ontario (Table 2). Nine key informants each from private clinics, Schedule 5 clinics and hospitals, as well as six informants from homecare, provided their perceptions and experiences regarding the partial delisting. The majority of informants were female, reflecting the landscape of PT providers in Ontario.

The GTA and Ontario subgroups were similar in their perception of the consequences of partial delisting. Four major themes emerged from the data: (1) change in demand, (2) change in access, (3) quality of care and (4) partial versus full delisting. Each theme is presented followed by the policy implications for each.

Table 2. Description of the Study Sample

<i>Provider Type</i>	<i>Ontario Subgroup (n = 18)</i>	<i>GTA Subgroup (n = 15)</i>	<i>Total (N = 33)</i>
Schedule 5 providers	5	4	9
Hospital providers	5	4	9
Homecare providers (funded through the CCACs)	3	3	6
Private practices	5	4	9
Female informants	13	7	
Male informants	5	8	

CCAC = Community Care Access Centre; GTA = Greater Toronto Area.

Change in Demand

The perceived impact of partial delisting on the demand for PT services depended on provider category. All participants from the Schedule 5 provider category reported an immediate decrease in demand for their services after partial delisting. As one Schedule 5 provider said:

“...it’s just the numbers are much, much less. The number of therapists that were here, it’s much less now. The number of assistants that are here, it’s much less. Everything has been scaled down.”

Conversely, informants from hospital, private practice and home care categories reported that they had not experienced any change in demand at the time of the interview. As noted by a homecare provider in the GTA, “Actually nothing has changed at the moment ...of course we’re waiting to see what transpires.” Similarly, a homecare provider in the Ontario subgroup noted “no difference—will know more in 6 months.” However, all reported that they felt the lack of change in demand was because the impact of delisting had not yet taken effect.

It was not evident from the data that physical therapists from hospital, private practice or homecare had implemented strategies to manage a change in demand for services. Moreover, many hospital informants reported that if there were to be an increase in demand, they would not be in a financial position to increase human resources to meet such a demand. Hence, they stated that they would likely have to increase their waiting lists or tighten their eligibility criteria for accessing services further. In general, the hospital and homecare providers expected a change but reported that they were adopting a ‘wait and see’ stance and had not implemented strategies to mitigate the real and/or potential consequences of the partial delisting.

Change in Access

All informants felt that, in time, there would be a significant decrease in access for clients. They also reported potential detrimental effects for clients between the ages of 20 and 64 years and those without private health insurance. All informants, irrespective of provider category, expressed general concern that prior to delisting, “the people who were accessing the Schedule 5 services were people [who] probably couldn’t afford it and didn’t have [private insurance] coverage.” Many informants were concerned that clients who could not pay out-of-pocket for services would not continue treatment elsewhere. The Schedule 5 providers reported that this was already

happening. As one said: "...none of those patients have since come back... I know there are people out there who could be using one-on-one therapy with a registered physiotherapist who have chosen not to because they have to pay for it. So there is definitely an impact of the partial delisting...."

There was general agreement that clients might be obliged to reallocate some of their personal finances to accommodate for decreased access to PT services. For instance:

...some people will now begin to divert some of their recreation/entertainment disposable income and be forced to use that for their own health needs... people will have to make some sacrifices in their lifestyle in order to manage their particular injury, their disability or their chronic condition.... It may impact their whole overall quality of life. I think that we're probably going to see patients begin to engage a little bit more in self care.... So there may be some inappropriate things happening there that might worsen their condition....

Subsequently, all providers expressed concern for clients' access options after delisting, feeling that they might end up having to access other sectors of the publicly funded health-care system to meet their needs. According to one informant from a less populated region of Ontario, some clients were being admitted by physicians for overnight hospital stays solely to become eligible to access OHIP-funded services under the new eligibility criteria. In addition, informants noted that the demand for physician services might increase:

I think we're probably going to see a greater burden of responsibility and care being placed on the physicians when people can't access publicly funded physiotherapy services. ...physicians will continue to manage the problems faced by some clients medically versus through physical medicine [therapy?] ...perhaps medication use will increase as opposed to dealing with the problems or other modalities that a physical therapist might engage in to resolve a problem.

Another reason offered regarding the decrease in access was the long wait times in other publicly funded PT services. Informants speculated that clients might try to access PT services through outpatient hospital programs; services are already difficult to access owing to strict eligibility criteria, long wait times and outpatient department closures. Homecare providers agreed that clients might attempt to access other services:

We're anticipating that the CCAC [homecare agency] are going to be expected to pick up more of these clients, just because people who would [have accessed Schedule 5 clinics], typically don't have third party pay type of insurance... From an affordability point of view...they're going to start to look to the CCAC for home care type of physiotherapy. So we're anticipating a potential increase in volume.

It was suggested also that clients no longer eligible for Schedule 5 services might opt to seek treatment in privately-funded settings. However, private practitioners remarked that although partial delisting might encourage some clients to use their extended health benefits, there would be a minimal shift toward private markets because many do not have such benefits:

I can't say that there would be a significant impact, an increase, because I think that people that wanted that kind of service would pay anyway. And if they had any type of insurance coverage they would probably take that to the limit and stop going at that point. ...there'll probably be a small increase in volume but not equal to the total number that were in OHIP [Schedule 5] clinics.

A few providers argued that partial delisting might result in increased access and shorter wait times for those who were 65 years or older and 19 years of age and younger. They reasoned that clients who remained eligible were "not competing with other patients, other adults that come into that [Schedule 5] clinic." In other words, if a client remained eligible for services in the newly termed Designated Physiotherapy Clinic, they might have improved access owing to lower volumes of eligible clients and a shorter wait list for this service.

Quality of Care

Despite their concerns about change in access to publicly funded PT services, providers (other than Schedule 5 providers) struggled with their perceptions surrounding the quality of care provided in Schedule 5 clinics. For example, a hospital provider noted: "I think some of the OHIP [Schedule 5] clinics that existed provided quite poor quality of care, and so I actually don't feel so bad that some of them will no longer be in operation ...it'll be better for people." The main reason offered for the perceived decreased quality was low payment structures per client visit. As a homecare provider said: "In order to maintain

their [Schedule 5 clinics] overheads they had to run a lot of volume through and that just makes it a little bit harder to give the real quality of care.” These perceptions reflect the historical tension^{33,34} that exists between Schedule 5 providers and those in other categories and led some participants to feel that quality of care might actually improve for those still able to access services. Even a Schedule 5 provider stated:

If I'm treating people who are paying to get treatment, first of all they'll be definitely more coherent and they'll comply with treatment... And second of all, I'll have more time to actually treat them.... So from that standpoint I see a benefit to this, from the actual physiotherapist's role. Because it's tough to see four people an hour.

Partial versus Full Delisting

All participants agreed that Ontario's decision to implement partial delisting was a positive alternative to full delisting. As one private practitioner said: “So it's actually positive... it's not great, but versus [full] delisting of course this is good.” Informants also stated that last-minute policy changes (from full to partial delisting) affected the degree to which the delisting impacted them: “We may have seen more of an impact if there hadn't been any of these last-minute negotiations in trying to fund a few things [e.g., clients 65 years of age or older and 19 years and younger].” A hospital provider in the Ontario subgroup stated: “If there were a full delisting, the hospital would have seen a larger impact. Most vulnerable are insured—a good decision for government.” Therefore, most providers reported feeling somewhat encouraged by partial delisting because it might promote services to the most vulnerable clients.

Providers from all categories also had extensive opinions on the delisting and its impact on the PT profession. One homecare provider felt that delisting had diminished PT's primary practitioner status in the health-care system. Another provider remarked that delisting “targets rehabilitation and people in rehabilitation ... I think the government doesn't clearly understand the need for rehabilitation...maybe the government doesn't value rehabilitation....” Despite this, providers in all categories remarked that the decision to only partially delist was more beneficial to the profession, especially compared with the full delisting of chiropractic and optometry services: “They [government] softened it up, a little bit ...it

kind of appears that, they might value physical therapy a little more....”, and “We're the only profession that's got something back. They didn't take it all away from us, so that says something good for us.”

In summary, all informants felt that partial delisting was encouraging for both the PT profession and clients who remained eligible for Designated Physiotherapy Clinic services. Maintaining services for targeted populations was deemed important because privatization of health care has been shown to have the greatest impact on the poor, unemployed, underemployed and elderly.³

DISCUSSION

Not surprisingly, the perceived consequences of partial delisting of publicly funded, community-based PT services were related to provider type. Schedule 5 providers reported a decreased demand for PT services at their clinics, whereas the remainder of providers in the other categories reported no immediate change in demand for their services. This finding relates to the concept of “elasticity of demand” for PT services in Ontario. Elasticity of demand refers to the change in the quantity of services demanded, resulting from a change in policy.³⁴ With the partial delisting of Schedule 5 funding, the policy change equates to a change in eligibility criteria for publicly-funded, community-based services.

The MOHLTC's policy decision to limit or restrict public funding for PT services in the former Schedule 5 clinics likely resulted from one primary assumption: that the demand for PT services is inelastic. Although it may seem counterintuitive, in an “inelastic” situation, the demand for PT service will not change as a result of a partial delisting decision. A client who is no longer eligible will access services from other publicly funded sources (e.g., hospitals, homecare) or from private sources (e.g., private practices). Alternatively, an elastic situation occurs if the overall demand for service changes following partial delisting; that is, clients no longer eligible for publicly funded services are unable to access PT providers in other areas. The market for PT services would be said to be elastic if, after partial delisting, clients chose to forego services based on their inability to pay out-of-pocket or were placed on wait lists.

Based on this study's findings, it appears that the demand for PT services was indeed affected. Based on the perceptions of physical therapists from different provider groups, clients who were no longer eligible for publicly-funded, community-based PT services may not have been accessing services elsewhere. In other words, partial

delisting appears to have affected clients in the former Schedule 5 clinics such that some opted to forego or terminate services rather than search for other care options or pay out-of-pocket costs. This finding is supported by data from the client component of this study, in which 20 of 113 clients (17.7%) discontinued therapy because they could not, or would not, pay for services using other sources after delisting.²⁸

Based on the perceptions among providers within the first month of partial delisting, our results suggest that further economic and health services research is required. Our findings parallel those of the only other Canadian study on delisting, which demonstrated that with delisting of PT services, the number of clients using PT services decreased, whereas the probability of clients seeking PT services increased, but only by those who had extended health insurance.²⁶ As forecasted in the literature and suggested by our findings, it appears that the demand for publicly funded services is susceptible to change following delisting and that client access to health services may depend on available funding. Additional research, including a larger sample and longer followup, is needed to explore this phenomenon.

With regard to the provincial government's policy decision, physical therapists in all provider categories perceived partial delisting to be a more positive option than full delisting, although partial delisting might have a long-term impact on the health of individuals not eligible for publicly funded services, such as those aged 20 to 64 years. Others have supported the notion that establishment of a health system accessible only to those who meet specific criteria may result in negative consequences in terms of decreased access and increased wait times.^{2,3,27}

Policy Implications

Given these findings, the potential long-term policy consequences for clients, providers and the health-care system will vary. The implications for each of these stakeholder groups are discussed separately.

Implications for Clients

Clients' interests may not be well served when access to services is restricted and when policy decisions limit overall availability of services. If partial delisting results in improved access to services among those who are most in need of services, as was purported when the MOHLTC partially delisted services, then the policy decision may

yield positive results regarding improved access and shorter wait times, but only for those who remain eligible.

Conversely, the interests of individuals who are no longer eligible for services may not be well served by such a policy change. Consider a client who is between the ages of 20 and 64 years, self-employed and without extended health benefits, the primary caregiver for elderly parents, with osteoarthritis in the lower spine and no longer eligible for OHIP-funded PT services. This person does not fulfill the eligibility criteria for PT, and if such services in the community are required, she or he will need to access other, publicly funded settings or decide to allocate personal resources to obtain PT. With some restorative PT services, this individual may be able to maintain mobility and function. Without such services, it could be argued that she or he might experience functional decline earlier than expected.

Implications for Providers

From the provider perspective, the consequences of delisting may be equally complex. If a Schedule 5 provider loses income because of partial delisting, this policy decision would be assumed to be negative. However, if a proportion of the clients whose treatments were being funded through OHIP decide to pay privately at a higher unit price, then the outcome may not be negative in that the majority of Schedule 5 providers also deliver services funded through private sources, such as extended health benefits. In all cases, the price per unit of services is higher in private funding sources compared with remuneration rates through OHIP. However, based on our findings, individuals who access services through OHIP may be unwilling or unable to pay privately, suggesting that the interests of the Schedule 5 providers may not be well served.

Regarding other publicly funded provider types, the interests of hospital and homecare providers may not be well served following partial delisting because they remain the only viable option for clients not eligible or willing to pay privately. Moreover, PT has become a highly competitive industry, especially in densely populated urban centres. Thus, a private practitioner who does not have the flexibility to invoice OHIP (even at low unit prices) may interpret partial delisting as a 'leveling of the playing field.' That is, they must now compete for clients on equal terms with Schedule 5 providers. Moreover, our findings indicate that individuals who accessed OHIP-funded services may not have had private insurance or may not have been willing or able to pay privately.

Implications for the Health System

As mentioned earlier, publicly funded health care costs are increasing, and the policy debate is now examining trade-offs that must be made to slow the rate of increase. Assuming no long-term financial effects of the delisting decision, the cost savings and/or improvement in access to services elsewhere may mean that this is a good policy decision. However, if delisting prevents access to individuals who require services and they need to enter the system via more expensive settings, such as hospitals, then the cost savings may be short-term.

Limitations

This study has limitations that are important to acknowledge. The time frame between implementing the partial delisting policy and conducting the research interviews was quite short. Originally, we set out to investigate full delisting, as planned by the MOHLTC, which was hypothesized to have a direct and immediate impact. However, owing to the last-minute MOHLTC change to partially delist, our decision to interview providers two weeks after delisting may not have allowed respondents sufficient time to perceive the impact of partial delisting on private, homecare, and hospital providers. To address this limitation, further followup interviews are currently being conducted with the providers one year after delisting.

Given the short time between the announcement of delisting and the actual delisting (10 months), we did not have time to apply for large-scale funding for this study. Instead, resources were assembled from a variety of sources. As a result, the resources were inadequate to transcribe all of the interviews. The use of student researchers allowed more extensive collection of data within the GTA at the expense of other areas of the province. We recognize also that the GTA is not necessarily comparable to less populous and more rural parts of the province.

CONCLUSIONS

This study explored the consequences of delisting from providers' perspectives in Ontario. All key informants view partial delisting of services as a more positive policy decision than full delisting since it preserved access to publicly funded services for senior and young populations. However, key informants expressed concern for individuals who would no longer be able to access services, for example, individuals with little disposable income and little or no private health insurance. The MOHLTC

suggested that individuals who were no longer eligible for publicly funded services might simply access PT in other publicly funded areas. However, our data cannot fully determine the degree to which clients shifted between settings or funding types. Perceptions among the providers were that delisting, partial or full, resulted in potential negative effects on the health status of some Ontarians. These concerns were subject to debate, however, as some felt that the quality of care provided in publicly funded clinics was not as good.

If this new policy increases the aggregate costs of a publicly funded system, then the wisdom of implementing it is questionable. On the other hand, if the decision to partially delist does not alter overall direct and indirect costs, then the decision may be interpreted as an appropriate policy, given the long list of financial demands elsewhere in the system. The early experience of providers suggests that some patients with previous public insurance no longer have access to PT. Further, long-term follow-up will provide more insight into the actual effects of delisting on those clients and their potential need for other services. Future research is also required to see what effect the market shock of de-insurance has on specific providers of PT services in Ontario. Although the interface between research findings and policy decisions is complex,³⁵ it may be important to consider the following question: Once such data are collected, analyzed and reported, will it be too late to change the funding policy to meet emerging and precarious demands for PT services?

Key Messages

What Is Already Known on This Subject

- To align supply and demand, provincial governments across Canada have begun the process of de-insuring or delisting services such as community-based physical therapy.
- Despite the fact that the perception and outcomes of delisting services are not fully known, Ontario partially delisted publicly funded, community-based physical therapy services in 2005.

What This Study Adds

- Our research has indicated that perceptions regarding delisting are dependent on provider type. However, all provider types tend to agree that delisting policies

restrict access and ultimately have an impact on health status among those no longer eligible for services.

- Further research is warranted to fully appreciate the impact of implementing delisting policies at the client and overall system levels.

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