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Title	The association of physician payment and team-based care with timely access in primary care: a population-based cross sectional study
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Reviewer 1	Braden Manns
Institution	Departments of Medicine and Community Health Sciences, University of Calgary, Calgary, Alta.
General comments (author response in bold)	This is a very interesting study that uses a novel dataset, and offers the possibility of linking health administrative data - specifically the model of primary care the survey respondent is enrolled in - with data on their access to health care when sick, their satisfaction and their awareness of after hours clinic (as well as other strong predictors of health care patterns of use (education; proxies of income; comorbidity). **We are glad the reviewer finds our study interesting and important.** It would be helpful to have a more detailed description of the 3 different funding models in a "box" or table. Why would physicians join a "nonteam capitation" model? They could get paid the same in a team capitation model and be given $ to hire allied health? What am I missing? I presume there are differences in the physicians who self-enroll in the 3 different models. Have previous analyses looked at this, and can this be incorporated into the table. Were the rolled out at different times? This table is important because you are suggesting that the different measures of access reflect the funding model (and it might) but it might also reflect the characteristics of the physicians who choose to join the 3 models (if you have info on the physician characteristics, including that would be a strength). You mention it in the discussion, but it seems that after hours care is mandated across all 3 models? Please include in the table. **The reviewer asks some great questions. We have added more information to the "setting and context" section to explain some of the nuances on team and team capitation. Due to the limit on the number of tables and figures, we have opted not to include an additional box or table on the funding models. The Hutchinson reference includes such a table should readers want more information.** **We have limited information on physician characteristics and have not included these in the paper. Instead, we have added the following statement to the limitation section to address the reviewer's concern ("joining new practice models was voluntary and differences we found may relate in part to differences in physicians who chose to join specific models that are hard to measure"). (Methods)** Table 1 seems organized in a strange fashion. I would suggest reporting the baseline characteristics overall... and categorized into the 3 exposure groups (the 3 funding models). The question is are there patient differences that might explain the differences across the 3 funding models, and without this, one can not determine this. **We thank the reviewer for this astute suggestion. We have moved the existing table 1 to the appendix and replaced it with a new table as suggested by the reviewer. (New table 1, new exhibit 2 of the appendices)**

	You also mention that those who responded to this survey tended to be healthier and wealthier that nonrespondents. Are you able to do stratified analysis in respondents you have who have higher health care needs (those who really need the same day access) – eg. Those with 2 or more chronic health conditions? It is possible that this might illuminate why some patients were satisfied when they got sick – but didn't have same day access (perhaps they had a URTI and didn't really need same day access) **The reviewer raises an interesting question that is unfortunately beyond the scope of our current work. We will definitely consider pursuing this question in future work. (n/a)** What is the impact of not having data from a community health centres? What services do they provide, and what data do they have that you don't have? **There is minimal impact from not having community health centre data as community health centres provide clinical care to <2% of Ontario's population (they also provide social and community services). We have revised the methods section to better explain why we did not include community health centre data (low numbers of respondents) (Methods)** Does OHIP registration in the last 10 years mean someone is an immigrant to Canada? If a person moved from Manitoba to Ontario, wouldn't they be put in this category? **The reviewer is correct that interprovincial migrants are also new registrants to OHIP. We estimate that the vast majority of new registrants are immigrants from elsewhere. We have edited the language in the sentence to clarify this and are careful to use the term recent registrant in the tables. (Methods)** The fact that capitation offers less access (based on one measure) is consistent with "theory" but actually past studies are a bit all over the place in what they have reported. It would be helpful if you could tease out "patients with higher health needs" – for whom same day access is actually needed. **The reviewer raises a great point, one that we will certainly consider for future work. Unfortunately, the question the reviewer raises is out of scope for our current study. (n/a)** If your analyses are confirmed in people with higher health needs, one conclusion of this work is that funding models in and of themselves haven't been very successful at meeting health system priorities. And in some ways, that is not surprising as new funding models often haven't been rolled out with appropriate accountability frameworks. Some discussion as to whether such frameworks exist – and how they are policed – would be helpful. **The reviewer raises a great point. We have added a sentence to the discussion to contrast our findings with findings from US patient-centred medical homes and suggested we may need more accountability aligned with medical home principles.**
Reviewer 2	Sarah Berglas
Institution	Patient Engagement, Canadian Agency for Drugs and Technologies in Health, Ottawa, Ont.
General comments (author response in	Well done. A widely relevant and clearly defined research question; with a well explained investigation and conclusion.

bold)	**We thank the reviewer for these positive comments! (n/a)** Introduction: Define 'capitation'. I had to look it up, and given the importance of understanding fee for service vs fee per person; well worth defining. Why a comparison to the Netherlands, does this country enjoy the greatest same day access? Why include the US given their generally private healthcare system; very different to Canada and the Netherlands. **We have revised the intro to include a definition of capitation. Netherlands is the top performing country when it comes to access, hence the comparison. We have made edits to clarify this. We have also deleted reference to the US and focused instead on Canada. (Introduction)** Methods: Define the 'new model' physicians use (page 7, line 6). Is this capitation / team based? **Based on feedback from the reviewer and editor, we have sharpened our language and now speak about Patient Enrolment Models consistently to refer to the three practice models we are comparing. (Methods)** Results: Similar results found as CIHI Commonwealth Fund 2016, with the important nuance that 70% respondents felt time to access was appropriate, given alternate options for care (telephone call, after hours clinic). Use 'team capitation' consistently rather than introducing 'Family Health Team (p12, line 8). A few lines on experience of those in the 'not rostered' practice model would be helpful. **Thanks for these observations and suggestions. We echo the reviewers first point in the interpretation section. We have replaced "family health team" with "team capitation" as suggested. We have not commented on 'not rostered' practices given the word limit and that this group was not the focus for our paper. We have added a few lines to the interpretation section about not rostered patients. (Interpretation)** Interpretation. Especially given the mixed results, I agree that 'timely access' should be measured multiple ways. Opportunities to interact with health professionals in non-traditional ways (by telephone, email, in after hours clinic, practice nurse, team doctor) add complexity to what is seen as appropriate by different patients / citizens. Could reference the HQO's Patient Partnering Framework in the need for patient / citizen participation in helping define these indicators. **We agree that measures should be informed by patients and have added this to our conclusion (and included the HQO reference per the reviewer's suggestion). (Conclusion)** I would be interested in learning more about the impact of telephone and email conversations on patient's definition of timely access; but see this as a future paper rather than exploring here. **We agree this is a potential area for future research and have added that sentiment to the conclusion. (Conclusion)**