Ontario's HSOs have not failed!

So "Ontario's HSO [Health Service Organization] program failed — at great expense — to achieve its objectives." This unreferenced statement in Dr. David Mowat's article "Primary care reform: Is it time for population-based funding?" (*Can Med Assoc J* 1997;157 [1]:43-4) is unfair, given that the HSO program has never been properly evaluated (except for a comparison of rates of admission to hospital, which showed no apppreciable differences between HSOs and fee-for-service practices).

Within the current contract, the costs for the medical primary care services provided by the multidisciplinary HSO teams are *below* the province's average per capita cost. Patients do not get assembly-line care, despite some perverse incentives in the current programs.[1]

Ontario's HSOs failed? By what measures and what studies?

Gary Gibson, MD
Professor of Family Medicine
University of Western Ontario
Member, Mustard Task Force
Member, Kilshaw Working Group
for the Victoria Report
Grandview Medical Center
Cambridge, Ont.

Reference

1. Gibson GA. Capitated practices. Do they work? [editorial]. *Can Fam Physician* 1996;42:589-92.

It is uncertain whether the Ontario Ministry of Health articulated its objectives and methods of assessment when establishing the HSO program in the early 1970s, but it is clear that many view with scepticism the role of HSOs in Canada's evolving health care network.

A perception exists that HSOs are more costly than the fee-for-service model. HSO funding arises from 2 sources: capitation (a preset monthly amount based on numbers of patients in various age and sex categories) and program funding (a negotiated sum that does not constitute physician income and which enables the HSO to administer "enhanced care" by ancillary medical staff). On the basis of data submitted by the ministry to the OMA in 1996, it has been calculated that per capita capitation costs of the HSO program are slightly lower than the corresponding fee-for-service averages. When program funding costs are added, per capita costs are slightly higher for the HSOs. However, the enhanced care programs reduce use of hospital-based services, which are traditionally funded by global hospital budgets.

Having worked within an HSO for over 10 years, I have come to appreciate that the benefits are intertwined with challenges. The dissociation between remuneration and "office visit" has enabled me to practise in a way that I believe is appreciated by patients, while affording me greater flexibility. My willingness to use the telephone (and even email) to communicate with patients would be difficult to duplicate in a "reformed fee-for-service" milieu. Even if the ministry links fees to telecommunication-based "visits," the frequency, brevity and variety (in terms of time and location) of physician-initiated patient contact will make remuneration for this contact cumbersome. Likewise, the ability to rely on allied health care professionals during patient visits has enabled our office to use physicians' skills to better advantage.

Although I remain a strong advocate of physician choice in compensation, I have difficulty understanding why, as Ontario searches to evaluate new ways to deliver high-quality primary health care efficiently, the HSO program has not received the attention it deserves.

David Wallik, MD
Chair, OMA-HSO Executive
Burlington, Ont.

[The author responds:]

Drs. Gibson and Wallik raise legitimate points which, because of space limitations, I was not able to address in my editorial.

One criticism of the HSO program as originally established was a lack of clear expectations.[1] Nevertheless, the program *was* expected to promote some specific changes in the provision of primary care, such as the placement of greater emphasis on clinical prevention and health promotion. A 1988 study[2] surveyed disease prevention and health promotion activities in HSOs, community health centres (CHCs) and fee-for service practices. At that time, HSO practice did not differ significantly from fee-for-service practices in terms of knowledge of or compliance with selected recommendations of the Canadian Task Force on the Periodic Health Examination. The increased use of nonphysician personnel was another aim. In general, the use of nonphysician health professionals has been modest.[2]

The important goal of reducing the rate of hospital admissions has received little study, but it is apparent, as Gibson states, that there are no significant differences between HSOs and fee-for-service practices, after physician and patient characteristics are taken into account.[3]

Difficulties with policies concerning the capitation rate, negotiation, arrangements for specialties and the Ambulatory Care Incentive Program